



FINAL REPORT

MISSOURI HEALTH INSURANCE
INNOVATION TASK FORCE



**REPORT TO GOVERNOR
MICHAEL L. PARSON**

JANUARY 2020



Office of the Director

January 31, 2020

The Honorable Michael L. Parson, Governor
State Capital Building, Room 216
Jefferson City, MO 65101

Re: Final Report of the Missouri Health Insurance Innovation Task Force

Dear Governor Parson:

It is my honor to present for your consideration the Final Report on behalf of the Missouri Health Insurance Innovation Task Force.

The Task Force was created by Executive Order 19-13 issued on July 17, 2019. The Task Force was charged with identifying innovations to improve access to affordable insurance options and access to health care services, particularly in rural areas of Missouri.

The Task Force has completed its work and offers for your consideration its recommendation, which proposes two (2) concepts to pursue through a Section 1332 Waiver. The Task Force believes these two (2) concepts meet the objectives you set forth in Executive Order 19-13.

1. Expand access to "catastrophic" plans that are currently limited to individuals 30 years of age and under, and those with some financial hardship. The Task Force recommends that catastrophic plans be made available to individuals over 30, under a limited set of circumstances.
2. Establish a state reinsurance program to cover a portion of claims in the individual market for very high-cost patients. Reinsurance programs have a proven track-record of significantly reducing premiums. Wakely Consulting, the actuarial firm retained on behalf of the Task Force, estimates a reinsurance program could reduce health insurance premiums in Missouri by as much as 29% in the first year.

I extend my sincerest appreciation to each member of the Task Force and to my colleagues at the Department of Commerce and Insurance for the long hours, hard work, and commitment to making health insurance more affordable to Missouri consumers.

Very truly yours,

A handwritten signature in cursive script that reads "Chlora Lindley-Myers".

Chlora Lindley-Myers



TABLE OF CONTENTS

| | |
|---|----|
| Executive Summary | 2 |
| Missouri Health Insurance Market and Health Care System | 2 |
| Challenges Identified | 5 |
| Task Force Objectives | 6 |
| The Recommendations | 7 |
| Concluding Remarks | 9 |
| Background | 10 |
| Public Comments and Task Force Testimony | 11 |
| Missouri Health Insurance Market | 12 |
| Existing State Waivers | 23 |
| Additional Waiver Concepts Considered | 30 |
| Final Recommendations of the Task Force | 38 |
| Expansion of Catastrophic Plans | 38 |
| Reinsurance | 43 |
| Conclusion | 48 |
| Appendix | 49 |
| Appendix A: Insurer Written Premiums (2018) and Covered Lives | 49 |
| Appendix B: Hospital/Facility Net Revenues (2018) | 57 |
| Appendix C: Public Comments | 66 |
| Appendix D: Summary of Task Force Testimony | 67 |

TASK FORCE MEMBERS

The following individuals were appointed to the Missouri Health Insurance Innovation Task Force by the Governor:



Chlora Lindley-Myers
Task Force Chair, Director
of the Missouri DCI



Andrea Croley
Co-Owner, Croley
Insurance, Springfield, MO



Coni Fries
Vice President,
Government Relations,
Blue Cross/Blue Shield of
Kansas City



Gary D. Fulbright
CFO, Citizen's Memorial
Hospital, Bolivar, MO



David K. Hill
Vice President and Deputy
General Counsel, United
Healthcare



Nathan T. Landsbaum
Plan President and CEO,
Home State Health Plan,
Inc.



Kandice K. Sanaie
Regional Director, CIGNA



Angela Brown, MPH
Acting Chief Executive
Officer, St. Louis Regional
Health Commission

Members of the Missouri General Assembly serving on the committee:



Senator Paul Wieland



Senator Bill White



**Representative
Jon Patterson**



**Representative
Justin Hill**



EXECUTIVE SUMMARY

The Missouri Health Insurance Innovation Task Force was created by an Executive Order issued by Governor Michael L. Parson on July 17, 2019. Executive Order 19-13 outlined the composition of the Task Force, which included stakeholders representing insurers, health care providers, consumers, and members of the Missouri General Assembly. The Executive Order specified that the Task Force be chaired by the Director of the Department of Commerce and Insurance.

The Task Force was charged with identifying innovative concepts to “improve access to affordable insurance options and access to health care services within the state while reducing the state’s uninsured rates, with a particular emphasis on increasing access to health care in rural areas of the state.” Any proposals from the Task Force were to be made within the parameters laid out in Section 1332 of the Patient Protection and Affordable Care Act (“ACA”) (42 U.S.C Section 18052), which defines a mechanism for states to seek waivers of certain provisions of the ACA to improve market performance in a way that better reflects local conditions and needs.

This report will provide a summary of the work of the Task Force, including a summary of data, information, and public comments received by the Task Force. The report will highlight unique challenges present in the Missouri health insurance market and the key policy objectives identified by the Task Force.

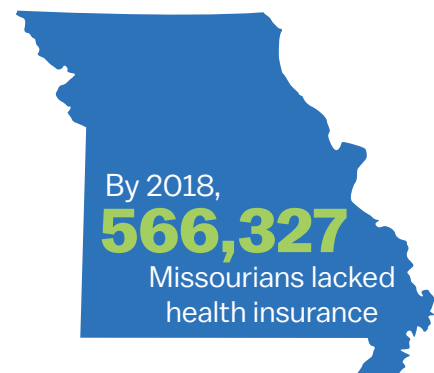
Finally, this report will provide the Task Force’s recommendations in terms of what the State should include in a potential Section 1332 Waiver Application.

THE MISSOURI HEALTH INSURANCE MARKET AND HEALTH CARE SYSTEM

To inform its work, the Task Force received information about the health insurance market in Missouri and the health care delivery system, which included the following:

- **Sources of Health Coverage.** Not all Missourians are covered under a health insurance policy that was sold by an insurance company. In 2018, the majority of Missourians with health coverage were covered through Medicare, Medicaid, or other government programs like Tri-Care (2,403,971 Missourians). The remainder of Missourians were covered under “commercial health plans.” Commercial health plans are comprised of two different types of plans: self-funded employer plans (2,070,938 Missourians) and fully insured insurance plans (1,767,257 Missourians).

This is an important distinction because the employer, not an insurance **company**, funds the health claims under a self-funded health plan. For that reason, these health plans are exempt from all state laws under ERISA, a federal law. By 2018, it was estimated that 566,327 Missourians lacked health insurance at some point within that year.

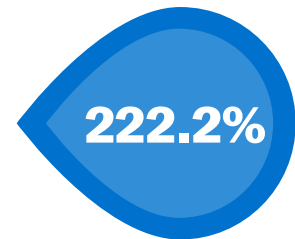




- **Increasing Health Insurance Premiums.** Between 2011 and 2020, the annual cost for a health insurance policy on the individual market more than tripled, rising from an estimated \$2,099 to \$7,582 per insured.

- **Increasing Health Care Costs.** Between 1991 and 2018, the Consumer Price Index (a measure of the change in costs of goods and services) in Missouri has risen by 73.24%. Over that same time period in Missouri, the CPI for health care services has risen by 222.2%. According to Missouri 2018 EDGE data¹ for the individual market, in-patient and ER claims comprised 24.9% of overall claims costs and non-generic drugs comprised 23.6% of overall claims costs.

1991-2018
CONSUMER PRICE INDEX FOR
HEALTH CARE HAS RISEN

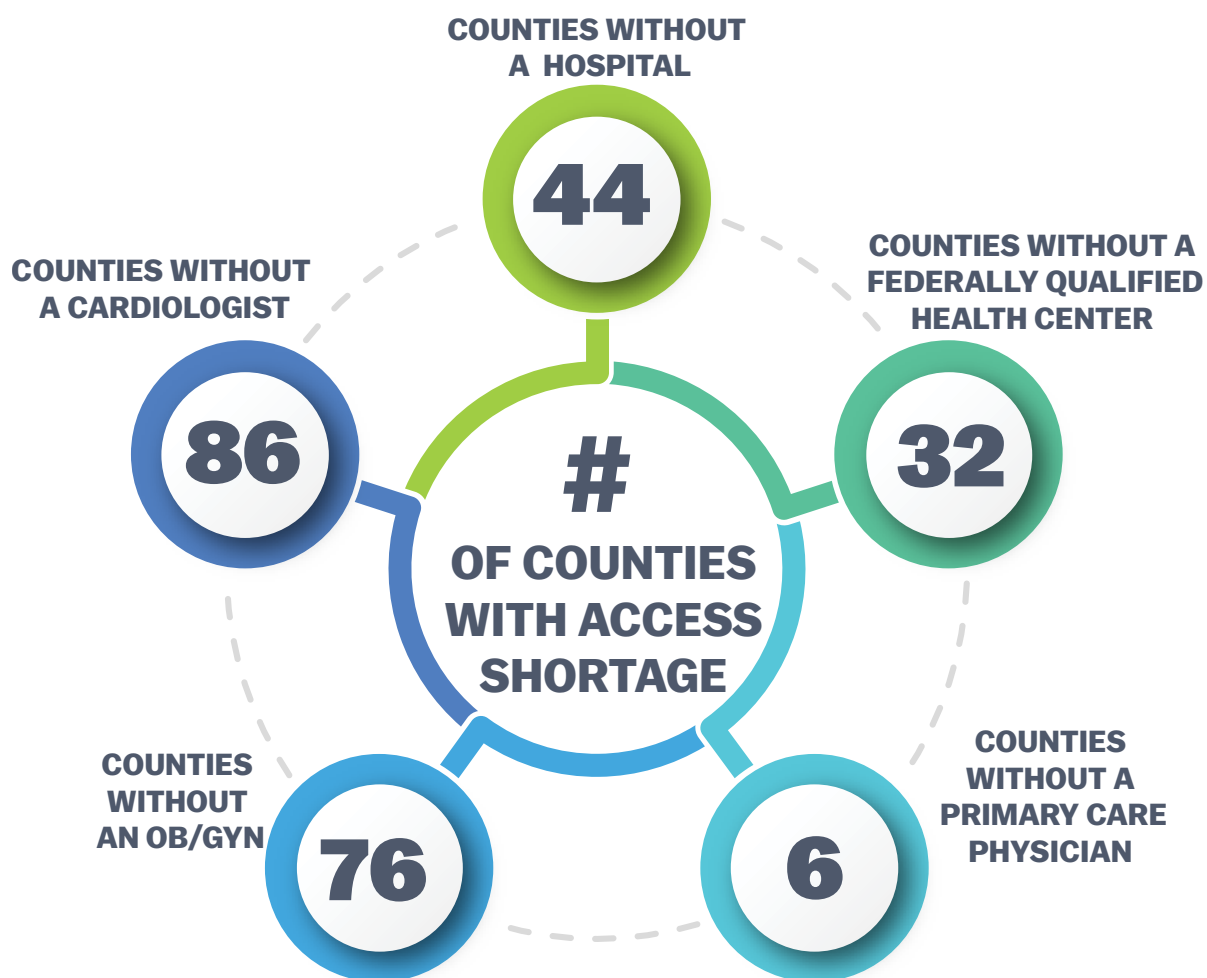


- **Consumers Lack Choice in Health Coverage.** In the individual health insurance market, the four (4) largest insurers control 95% of the market (by premium volume). For 2020, 77 of Missouri's 114 counties² have only a single insurance company selling insurance policies on the federal marketplace.

¹ EDGE Server Data: Enrollee-Level External Data Gathering Environment (EDGE). A database that contains claims level data for covered individual and small group health insurance plans. The dataset is composed of 4 data files: enrollment, medical claims, pharmaceutical claims and supplemental claims. Some de-identified limited data set files are available to researchers upon request. https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/Data-Disclosures-Data-Agreements/DUA_-_NewLDS.

²For ease of reading throughout this report, 114 counties also incorporates by reference the City of St. Louis, an Independent City not within a County.

- **Decreased Access to Health Care in Rural Areas of Missouri.** Throughout rural Missouri, there are increasing issues with access to providers and hospitals. These shortages mean Missourians must travel long distances for care. Shortages also impact health insurers' ability to negotiate and establish adequate networks and reduce their negotiating power in terms of reimbursement rates. Data obtained by the Department show that there are 44 counties currently without a hospital. There are 32 counties that don't have a Federally Qualified Health Center (FQHC). There are 6 counties without a primary care physician residing in the county, 76 counties without any obstetricians/gynecologists residing in the county, and 86 counties without a cardiologist residing in the county.



CHALLENGES IDENTIFIED BY TASK FORCE

Through its review and consideration of the above information, the Task Force identified five (5) key challenges serving as obstacles to health insurance and health care for Missourians. The challenges are:



Lack of choice. Most Missourians have limited choices in health plans and health insurance companies.



Too many Missourians are being “priced out” of health insurance coverage by rising premiums and increasing out of pocket costs. In many cases, individuals are not eligible for premium tax subsidies. In other cases, Missourians evaluate the premiums in relation to the benefits under the policy and decide they will risk going uninsured.



Missourians in rural areas of the State have problems accessing the health care they need and want. There are high concentrations of Medicare and Medicaid populations in some of these rural counties, both of which have significantly lower reimbursement rates. As a result, providers and hospitals are closing or leaving. There are shortages of hospitals and health care providers in rural counties.

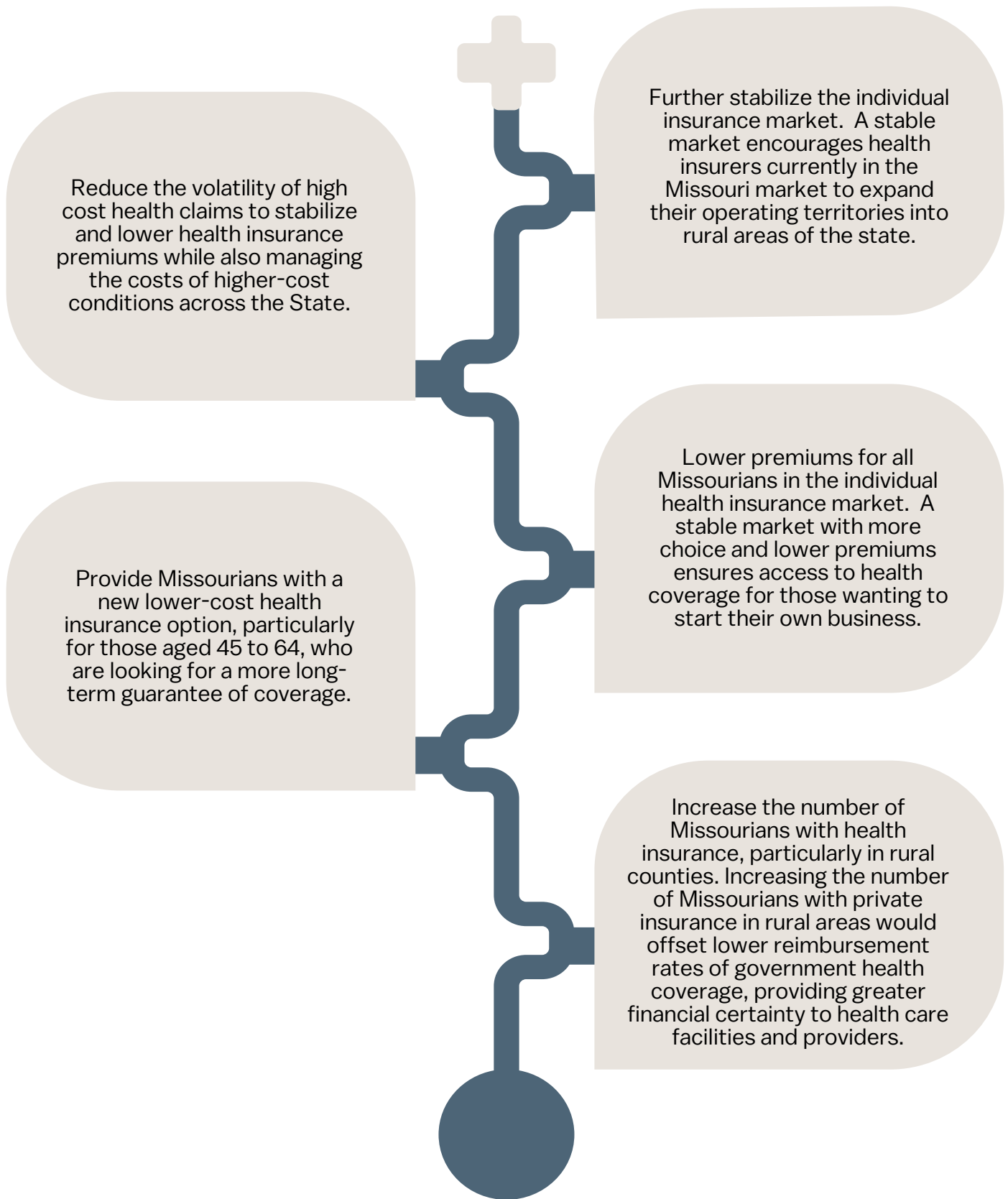


Higher-cost chronic conditions account for the majority of overall claims costs in the individual market. Twenty percent of those insured incur 80% of the total claims costs.



Too many Missourians don’t have health insurance. Hospitals and other providers are continuing to see high levels of uncompensated care. For hospitals, this uncompensated care is partially addressed through Disproportionate Share Hospital Payments (DSH). DSH payments are partially funded by a hospital provider tax, serving as the state’s match, to draw down additional federal funding. Outside of these federal subsidies, the additional costs are passed along to other health care consumers, which increases health insurance premiums.

TASK FORCE OBJECTIVES



THE RECOMMENDATIONS

The Task Force spent a considerable amount of time working through various concepts in an attempt to address the objectives identified above through a Section 1332 Waiver. Ultimately, the Task Force agreed upon two (2) concepts it believes will provide Missourians with more affordable choices for health insurance coverage and which will continue supporting a fragile rural health system. This report will provide more detail on these two (2) recommendations, as well as other options considered by the Task Force. This report will also include the analysis and findings of Wakely, the actuarial firm working on behalf of the Task Force.

Recommendation #1

EXPAND THE AVAILABILITY OF CATASTROPHIC PLANS

Eligibility for catastrophic plans is currently limited under the ACA to individuals age 30 and under, and those over 30 who meet various financial or other hardship requirements. The Task Force recommends extending eligibility to those over the age of 30 who have not had ACA-compliant coverage in the preceding year.

This recommendation reflects two specific and important goals:

Minimize disruption to existing catastrophic policyholders; in other words, avoid increasing rates or reducing benefits for those currently enrolled in a catastrophic plan; and

Provide an additional lower-cost option for older individuals who would otherwise go uninsured or rely on short-term coverage.

From Wakely's analysis and findings, the new catastrophic plan could produce significant premium savings for uninsured or underinsured individuals. As an example, for an individual aged 27, the annual savings are estimated to range from \$340 to \$1,200 a year, depending on rating area and final rating parameters approved by CMS. For an enrollee aged 55, annual savings are estimated to range from \$730 to \$2,600 a year. These savings could increase if CMS allows these new catastrophic plans to include adjustments for morbidity (allowing rates to be adjusted for catastrophic plans differently than the rest of the individual market).

For an individual aged 27, annual savings are estimated to range from \$340 to \$1,200 a year

Recommendation #2

CREATE A REINSURANCE PROGRAM

Generally speaking, a reinsurance program such as the one that is proposed here, serves to spread higher-cost claims amongst a larger pool, thereby lowering overall premiums in the individual market. Reinsurance programs also have the benefit of reducing the volatility of claims. As claims costs become more predictable and certain, the result is lower paid claims projections by insurers which leads to lower rates/premiums.

This recommendation reflects three specific and important goals:

Reduce the volatility of high cost health claims and further stabilize the Missouri individual insurance market.

Encourage new insurers to enter the Missouri insurance market and existing insurers to expand their service areas into rural areas of Missouri.

Lower premiums for all Missourians who get their health coverage through the individual market. This includes those who don't have health coverage through their work and for those starting a business. It is estimated this proposal could reduce premiums by as much as 29%.

In addition, through the Section 1332 Waiver process, states can recapture federal dollars that would otherwise be spent on advanced premium tax credits (APTC). In other words, if the reinsurance program is projected to lower premiums (also reducing what the federal government would spend on federal premium tax credits), then the State can receive or draw down those savings – called “pass-through” payments. A state can reinvest any federal pass-through funding back into the reinsurance program to further lower premiums.

Depending on the final structure, as further detailed later in this report, Wakely, the actuarial firm retained by the Task Force estimate that a reinsurance program could reduce premiums in the individual market by between 10 and 29% in the first year of implementation.

A reinsurance program could reduce premiums in the individual market by between 10 and 29% in the first year of implementation.

CONCLUDING REMARKS

Reinsurance programs are a proven private sector tool in managing difficult insurance markets. Twelve (12) states have implemented a reinsurance program and at least three (3) other states are contemplating or are in the process of obtaining approval to operate a reinsurance program through a Section 1332 Waiver. A reinsurance program has been the single most commonly used tool by states to lower premiums in the individual health insurance markets.

A reinsurance program will further stabilize the individual health insurance market. A well-designed reinsurance mechanism can reduce the volatility of high-cost claims and, in turn, lower insurance premiums. A more stable market will encourage insurers to expand their service areas into the rural parts of the state, increasing access to more affordable insurance coverage. Lower health insurance premiums that are more affordable for the average Missourian will also help lower the uninsured rate in the State. A lower uninsured rate will benefit the State, but it will also benefit health care facilities and hospitals by reducing the level of uncompensated care.

The expansion of catastrophic health plans will provide Missourians currently without insurance another lower-cost coverage option to choose from. Producer representatives on the Task Force noted this will be a particularly attractive option to those aged 45-64. It will also benefit those individuals wanting to leave employment with health coverage to start their own business. These individuals need the certainty of guaranteed issue coverage that is affordable in order to make that type of life change.

The Task Force believes, that together, these two recommendations meet the objectives the Task Force identified early on. Likewise, they meet the objectives given to the Task Force under the Executive Order.

“

Reinsurance programs make payments for individual market plans based on actual costs rather than predicted costs. By making these payments, the programs help cover high-risk patients with ongoing and costly health care, as well as low-risk enrollees who might experience high and unexpected health care costs ... these payments are designed to **reduce premiums for working families.**

- *National Conference of
State Legislatures*

”

BACKGROUND

Section 1332 of the ACA establishes a process by which states may apply to the Departments of Health and Human Service (HHS) and Treasury to waive specific provisions of the Act. Specifically, states may apply to modify rules related to:

Essential Health Benefits: States may seek to alter required coverages and benefits, including the actuarial value metal tiers established by the ACA (gold, silver, etc.).


Operation of the Exchange: The marketplace through which plans are sold may be subject to alteration in design and function, including the permissible plans allowed to be sold on the marketplace.

Subsidies: Rules governing subsidies available to insureds, such as advanced premium tax credits (APTC) and cost-sharing reductions (CSR), may be modified, including eligibility standards and the amount of subsidies.

Employer Mandate: The requirement that employers with 50 or more employees make coverage available to employees or be subject to fines, can be eliminated or modified. Across each of these areas, states are afforded fairly broad latitude to develop innovative ways to provide more affordable coverage, assess ways to segment and finance risk pools, establish reinsurance programs, explore ways to incentivize more efficient and efficacious delivery and coordination of care, and make subsidies available, among other things. However, large portions of the ACA may not be waived, including the prohibition on underwriting and rating based on preexisting health conditions, guaranteed issue of coverage, and the characteristics that may be used in rating (permissible rate differentials based on age, geography, smoking status, etc.).

In addition the waiver provision specifies numerous “guardrails,” or constraints related to the impact of such a waiver. A state waiver may not lead to increases in the federal deficit, and must ensure the continued availability of coverage that is at least as comprehensive and affordable as would be available without the waiver. Any savings that accrue to the federal government may be returned to the states in the form of “pass-through” funding.

PUBLIC COMMENTS AND TASK FORCE TESTIMONY



Nearly all of the comments advocated for a reinsurance program to assume the risk of the most chronically ill and high-cost insureds.

Comments from interested parties were solicited to assess concerns of various stakeholders. Insurers, health care providers, associations, and other commenters expressed a wide variety of suggestions. The Task Force discussed the comments at length during its October 10, 2019 meeting.

Many of the comments urged the Task Force to identify ways to reduce core health care costs, primarily through patient incentives and improvements in health care delivery and management. Seven comments pertained to alterations in the insurance market, such as recommending changes in benefit designs, or

favoring alternative arrangements such as association health plans. Four of the comments referenced short-term plans, however, two of the commenters argued against the expansion of such plans on the grounds that they typically offer less-generous benefits than ACA-compliant plans. Additional comments offered miscellaneous suggestions, such as an optional buy-in to Medicaid, requiring insurers that participate in public programs to also offer plans in the individual commercial market, and reforms designed to improve market efficiency such as price transparency or plan standardization.

In addition to the public comments, the Task Force heard testimony from a variety of subject matter experts, including representatives from the Center for Consumer Information and Insurance Oversight (CCIO), insurance commissioners, other insurance regulators, health care professionals, academics specializing in health policy, and IT personnel, among others. Over the course of its work, the Task Force focused on just a few proposals, and ultimately narrowed recommendations down to two – a reinsurance program and an expansion of eligibility criteria for “catastrophic coverage,” consciously designed to minimize any impact on those already insured.

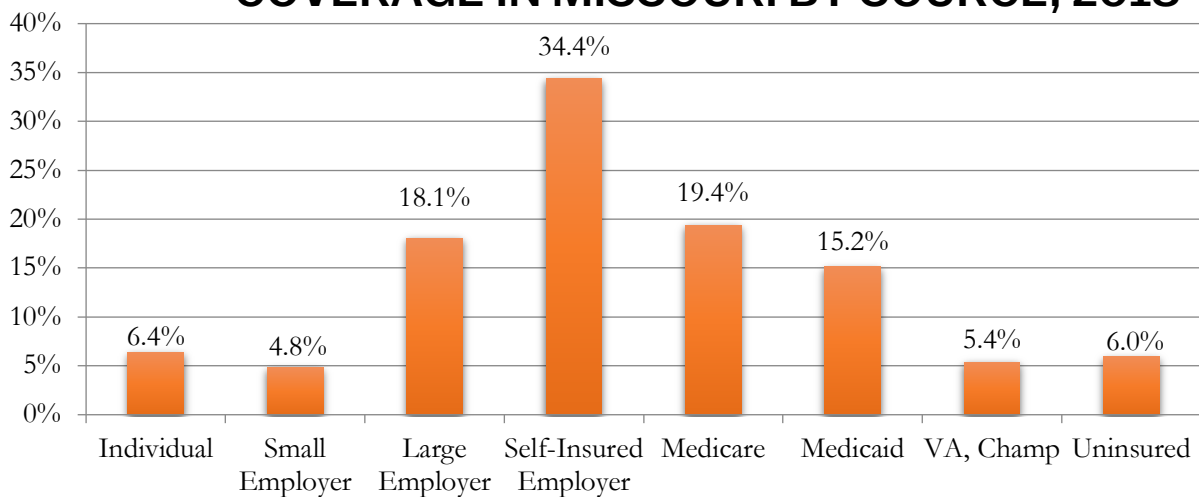
A link to public comments can be found in Appendix C. A summary of testimony presented to the Task Force can be found in Appendix D.

THE HEALTH INSURANCE MARKET IN MISSOURI

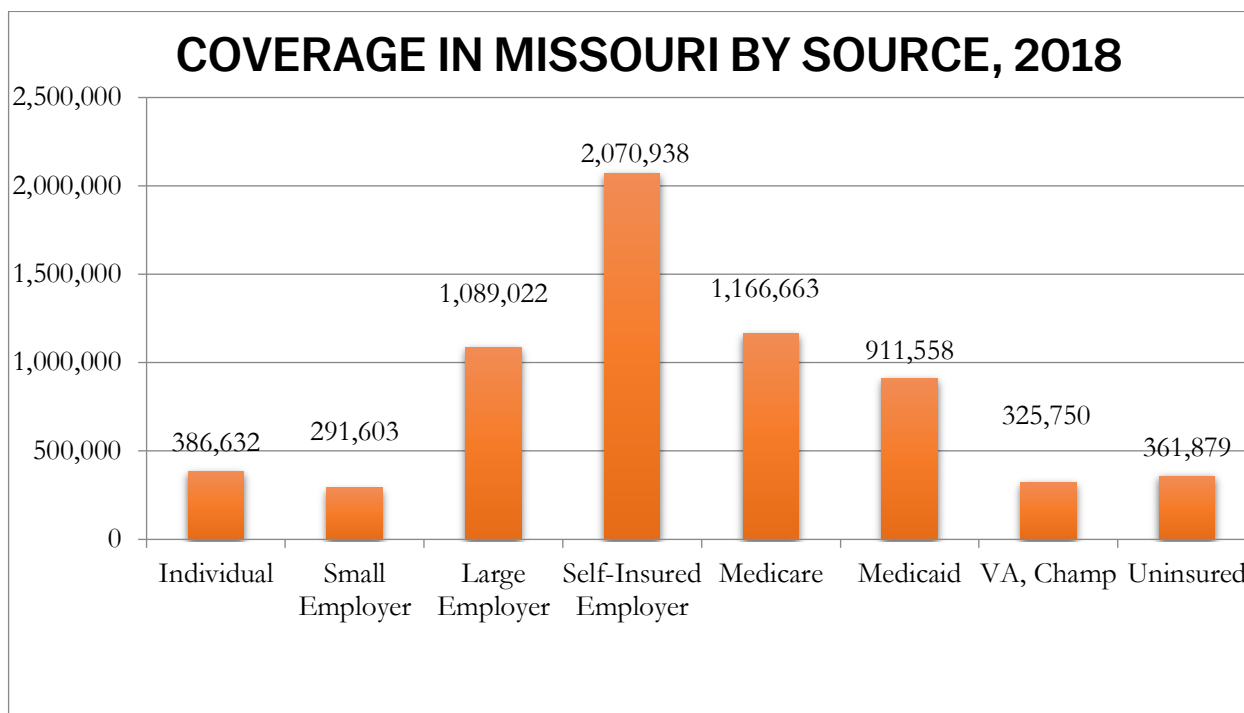
Approximately 64 percent of Missourians obtain health insurance coverage in the private market. Of these, a significant majority have coverage through employer-sponsored plans. Drawing on a variety of data sources, the DCI produced the following estimates of the size of various market segments. It is estimated that approximately 380,000 Missourians obtained fully-insured³ individual coverage – that is, coverage not associated with employment – at some point during 2018.

It is estimated that approximately 380,000 Missourians obtained fully-insured individual coverage – that is, coverage not associated with employment – at some point during 2018.

COVERAGE IN MISSOURI BY SOURCE, 2018



³ This figure excludes public programs such as Medicaid and Medicare. The estimate is derived from a combination of insurer financial statements, plus data from the Current Population Survey (CPS) and the American Community Survey (ACS). See next page for details.



Source: Estimates produced by DCI employing data from the American Community Survey (ACS), the Current Population Survey (CPS), and insurers' financial annual statements. Percentages represent individuals with a given source of coverage at any point during 2018. The uninsured percentages reflect those individuals who lacked coverage for the entirety of 2018. As such, percentages may total to more than 100, as individuals can have more than one source of coverage during the year.

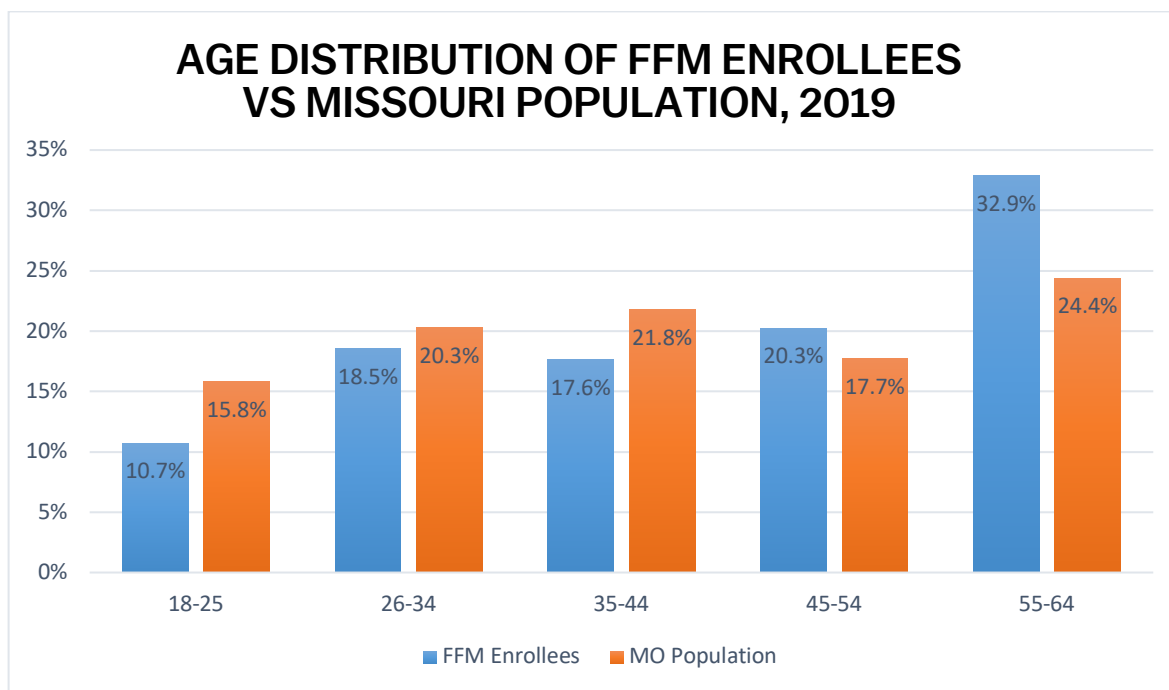
Prior to the passage of the ACA, individual-market policies were typically underwritten. That is, insurers made determinations about each individual's medical risk, such as their family medical history, whether they exhibited various health conditions, or other predictors of health risk. Pre-existing health conditions could be excluded from coverage, or an insurer could refuse to issue a policy altogether – or set rates that were unaffordable for many potential insureds.

Among the market reform provisions enacted through the ACA was a prohibition on medical underwriting based on pre-existing conditions. While insurers were permitted to rate based on age and smoking status, rating differentials were limited, and all policies were made “guaranteed issue” – all comers were eligible for coverage. This reform alone had multiple effects. Coverage became available to individuals previously excluded from the individual market due to poor health. Such reforms, in addition to federal subsidies, had a demonstrable impact on uninsured rates, which decreased in Missouri from over 13 percent in 2012 to 6 percent in 2018.⁴

However, the same market reforms may have led to a degree of “adverse selection,” in which healthier individuals drop out of the market in response to price increases associated with an increase in claims costs. While quality data are scarce, guaranteed issue unquestionably had the effect of changing the composition of the risk pool in the individual market, driving up overall claim costs.

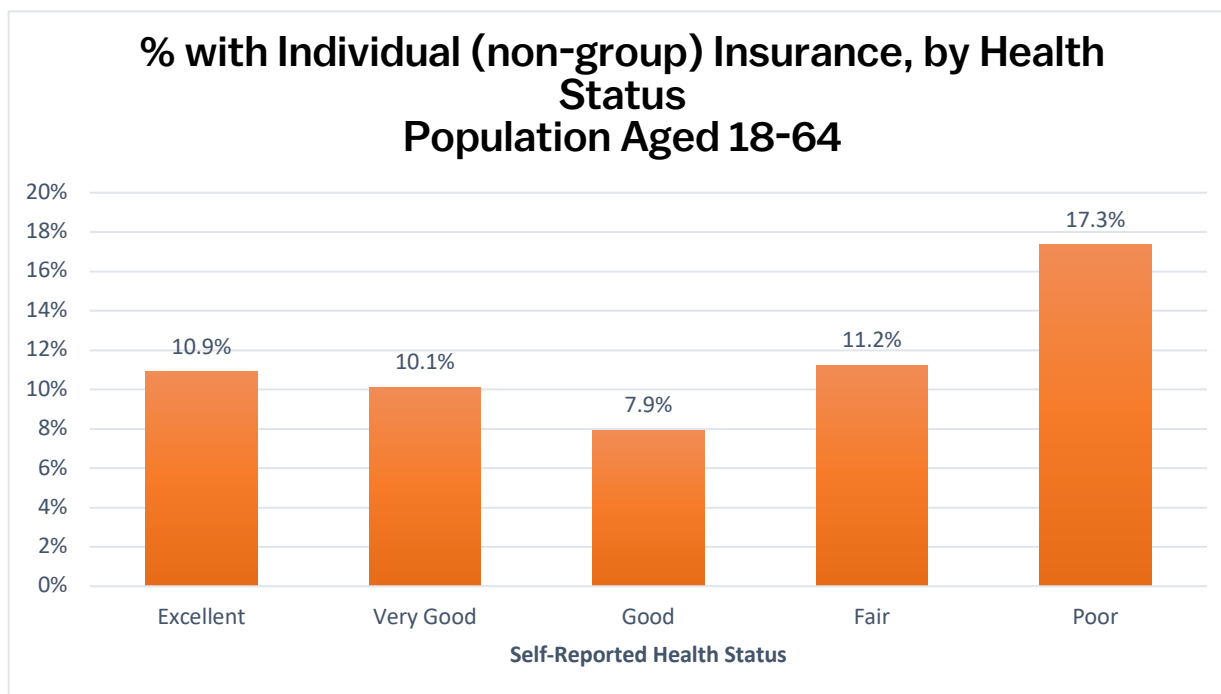
⁴ Calculated by DCI from the Current Population Survey. Note that a change in question wording on the CPS in 2013 led to somewhat lowered uninsured estimates, but it is clear that a substantial decline in the estimate reflects an actual decrease.

While direct evidence of such adverse selection is not readily available, some data are suggestive. One imperfect but useful proxy of health status is age. Data indicate that younger age cohorts are underrepresented in the federal marketplace, while older cohorts, particularly the 55 – 64 age group, are significantly overrepresented. While this age group comprises 24.4 percent of the adult population (those aged 18 to 64) in Missouri, they represent 32.9 percent of federal Marketplace enrollees.



Source: Federally Facilitated Marketplace (FFM) Enrollment obtained from CMS, State-Level Public Use File. Missouri population data calculated by DCI from Current Population Survey data.

Additionally, the Current Population Survey (“CPS”) – Socio-Economic Supplement⁵ – collects data about both insurance coverage and health status of respondents. The CPS health status question has been shown to be a reasonable proxy for actual health status, and has been shown to be correlated with such items as actual diagnoses or health care expenditures. The majority of individuals rating themselves in poor health are covered by public programs in Missouri. However, a disproportionate percentage of Missourians reporting poor health also obtain coverage in the individual market, with very few insured by employer-sponsored coverage (not shown).

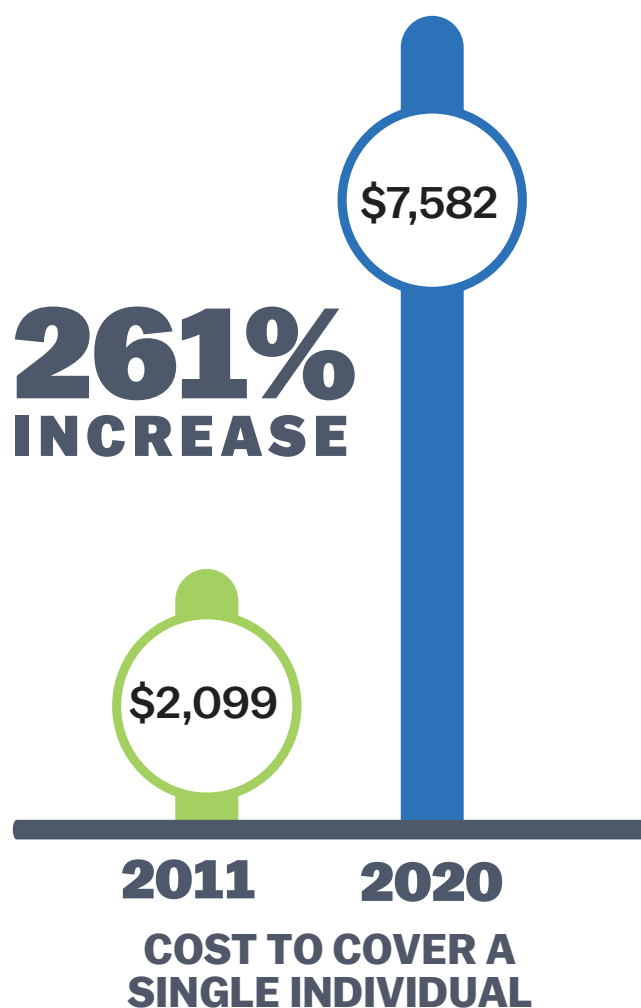


Source: Current Population Survey – Socio-Economic Supplement, 2019. Data for Missouri.

⁵ The Current Population Survey (CPS) is conducted monthly by the Census Bureau. The Socio-Economic Supplement to the CPS is conducted in March of each year and collects detailed socio-economic data as well as information about health insurance coverage. The large sample size of this survey permit inferences at the state level.

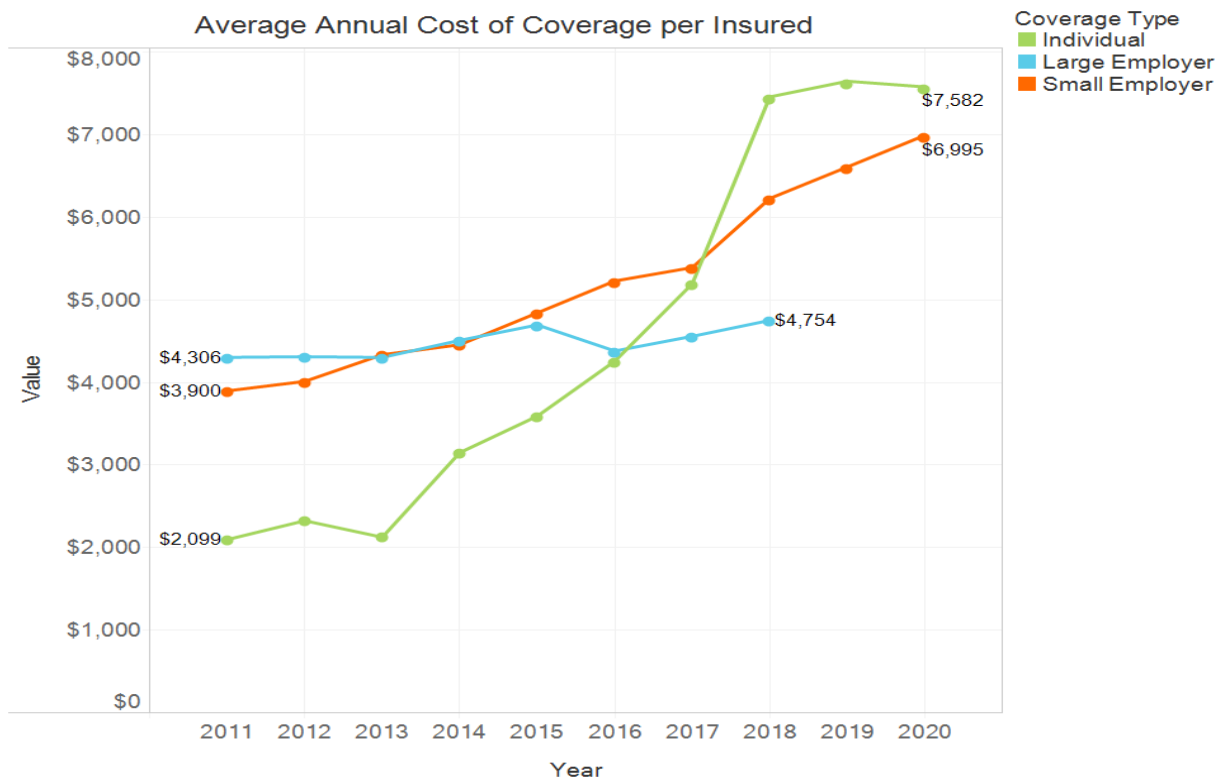
While the cost of coverage did not increase appreciably in the large employer market, costs in the small group and especially the individual market most impacted by adverse selection, rose substantially. Between 2011 and 2020, the cost to cover a single individual for one year increased by 261 percent, rising from an annual cost of \$2,099 to \$7,582. That rate of increase far outpaced the rate of health-care inflation, which is expected to increase by about 25 percent over the same time period.⁶

It appears that the costs in the individual market stabilized by 2019, and by 2020 premiums slightly decreased. This interpretation is buttressed by the fact that insurers will rebate over \$25 million to consumers in 2019, representing the difference between claims costs and the target medical loss ratio of 80 percent mandated by the ACA.



⁶ Health care inflation is measured by the Consumer Price Index for Medical Costs for St. Louis. The Health-Care CPI increased by slightly over 21 over the 2011 to 2018 period, which is the latest year available at the time of writing.

| Average Annual Cost of Coverage per Insured Missouri | | | | | | |
|---|------------------------|-------------------|----------------|-------------------|----------------|-------------------|
| | Individual Coverage | | Small Employer | | Large Employer | |
| Year | Cost | Percent change | Cost | Percent change | Cost | Percent Change |
| 2011 | \$2,099 | | \$3,900 | | \$4,306 | |
| 2012 | \$2,327 | 10.9% | \$4,015 | 2.9% | \$4,314 | 0.2% |
| 2013 | \$2,127 | -8.6% | \$4,338 | 8.0% | \$4,305 | -0.2% |
| 2014 | \$3,152 | 48.2% | \$4,459 | 2.8% | \$4,512 | 4.8% |
| 2015 | \$3,594 | 14.0% | \$4,845 | 8.7% | \$4,699 | 4.1% |
| 2016 | \$4,260 | 18.5% | \$5,231 | 8.0% | \$4,383 | -6.7% |
| 2017 | \$5,198 | 22.0% | \$5,394 | 3.1% | \$4,561 | 4.1% |
| 2018 | \$7,461 | 43.5% | \$6,231 | 15.5% | \$4,754 | 4.2% |
| 2019 | \$7,651 | 2.5% | \$6,612 | 6.1% | N/A | N/A |
| 2020 | \$7,582 | -0.9% | \$6,995 | 5.8% | N/A | N/A |
| Change, 2011 to 2020 | | 261% | | 79% | | |



Source: Calculated by DCI. 2011-2018 estimates are derived from insurers' financial annual statements, and are the ratio of (earned premium / member years). 2019-2020 estimates were obtained from insurer rate filings with the DCI and represent the average rate change across filings weighted by the number of impacted insureds. Large employer rates are exempt from filing requirements, so estimates are derived from insurers' financial annual statements and are only available through 2018.

Market Competition

Health insurance markets in Missouri, as in most states, are among the least competitive lines of insurance, with market share concentrated among just a handful of large insurers. In 2018, the market share of the largest four insurers exceeded 90 percent in both the small and large group markets, and 95 percent of the individual market. By way of comparison, the top 4 insurers controlled 53 percent of the private automobile insurance market and substantially less than 50 percent of the workers compensation and commercial multi-peril markets.

| Market Concentration Indices, 2018 | | | | |
|---|-----------------------------------|-------|--------------------|--------------------|
| Line of Business | Insurer Groups w > \$100k Premium | HHI | Top 4 Market Share | Top 8 Market Share |
| Health Insurance (Major Medical Policies Only) | | | | |
| Individual (including Association) | 8 | 2,831 | 95.1% | 100% |
| Small Group | 7 | 2,830 | 92.9% | 100% |
| Large Group | 10 | 2,680 | 92.9% | 100% |
| Property & Casualty Lines | | | | |
| Private Auto | 60 | 1,001 | 53.1% | 74.3% |
| Homeowners | 50 | 1,140 | 56.9% | 74.5% |
| Commercial Auto | 89 | 372 | 30.2% | 43.5% |
| Workers Compensation | 88 | 952 | 47.5% | 61.9% |
| Commercial Multi-Peril | 78 | 382 | 28.0% | 46.4% |

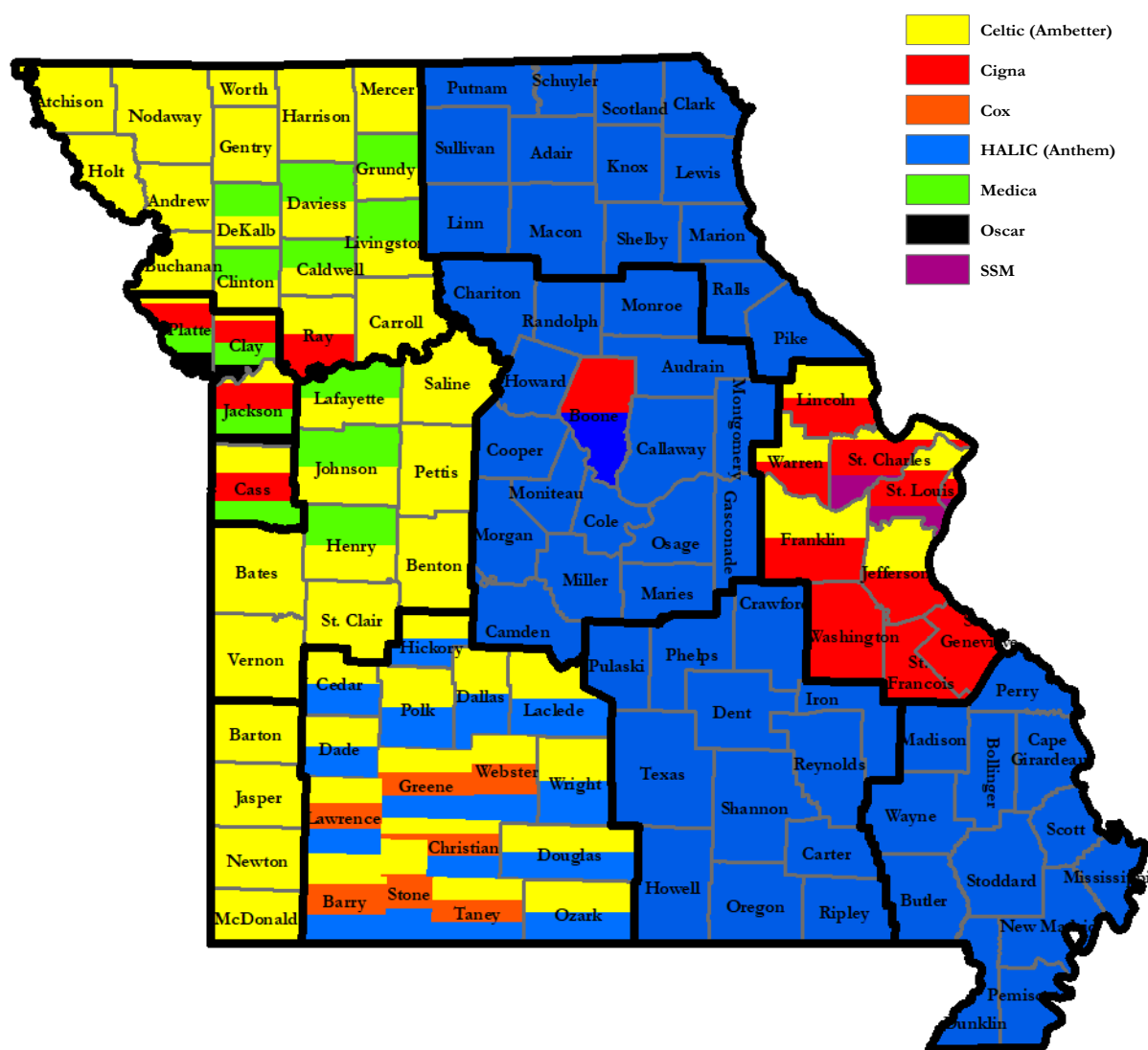
Another widely employed measure of market competition is the Herfindahl-Hirschman Index (HHI). The HHI is calculated as the sum of the square market shares of all insurers. This index may range from near 0, representing a highly competitive and fragmented market, to 10,000, representing a line of business dominated by a single firm. While the index values have no intrinsic meaning, the Anti-Trust Division of the Department of Justice provides one commonly used guideline:

- A. Below 1,000: Unconcentrated or competitive
- B. 1,000 to 1,800: Moderately concentrated
- C. Over 1,800: Highly concentrated

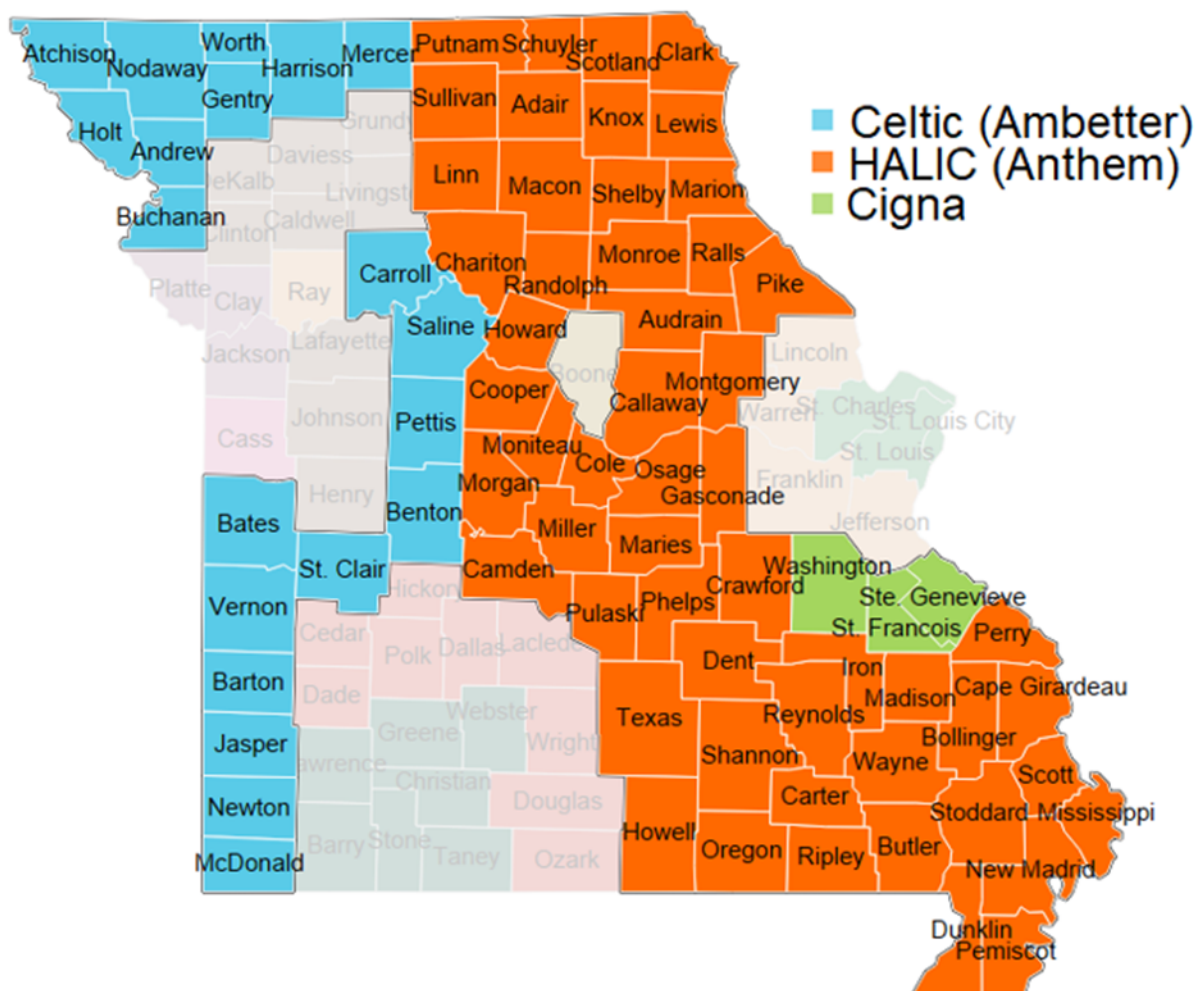
Each of Missouri's commercial health insurance markets is considered "highly concentrated" by this measure. The statewide figures understate the level of market concentration, as insurers do not operate in all areas of the state. While market share data are not available for sub-state regions, data are available for policies sold on the Federal Marketplace.

As illustrated in the map below, the majority of counties outside of the St. Louis, Kansas City and Springfield metro areas only have a sole insurer offering products on the federal Marketplace. While more insurers entered the market in 2020, expansion was nearly exclusively in the large urban areas of the state.

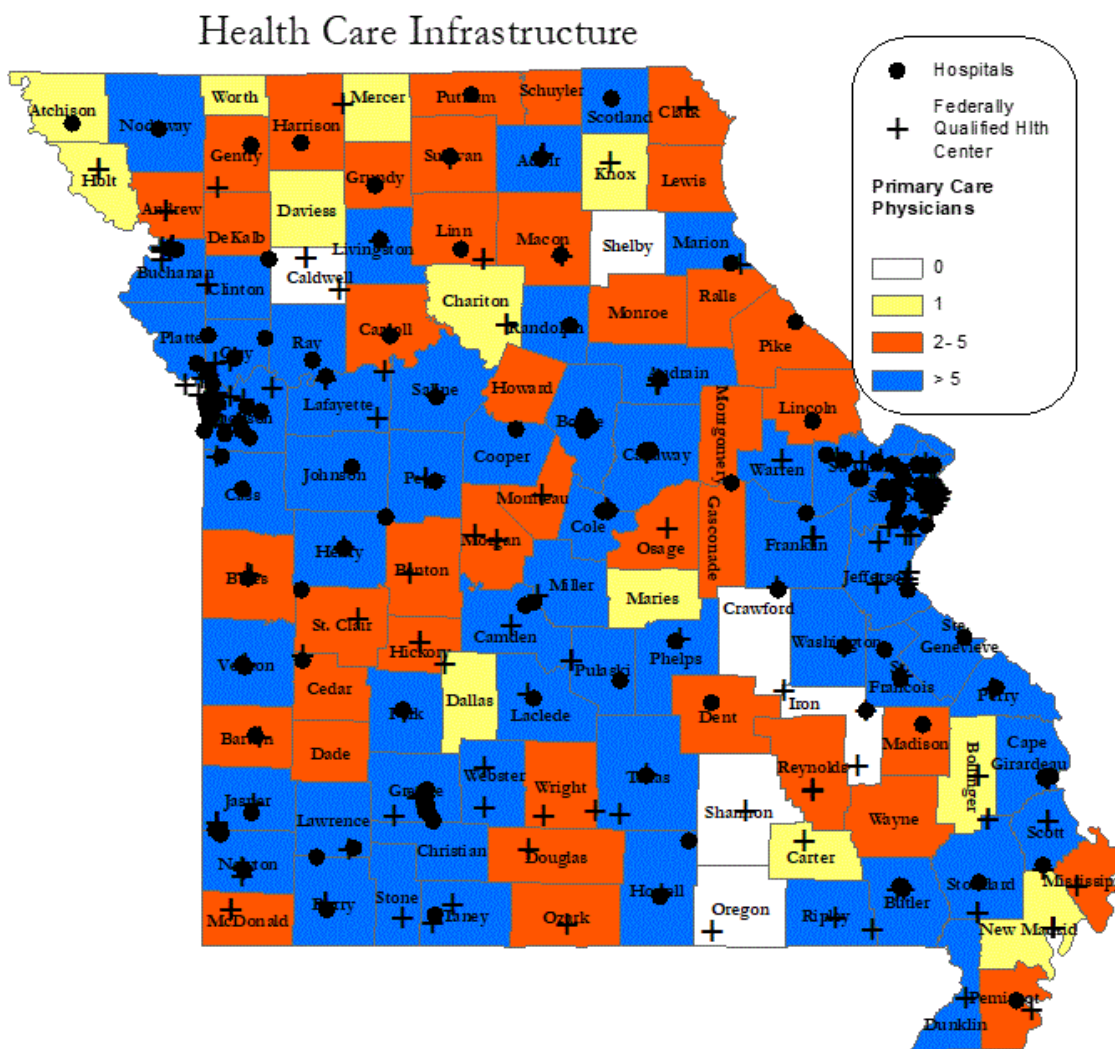
Insurers in the Federally Facilitated Marketplace, 2020



In 2020, 77 of Missouri's 114 counties have only one insurer offering coverage on the Marketplace. An additional 24 counties have just two active insurers. While this is a slight improvement over 2019, a significant portion of the state confronts limited choices of carriers offering coverage in the individual market.



In general, choices are more restricted in rural areas of the state, a situation amplified by a shortage of health care providers. Many counties lack basic hospital facilities. In 2017, six Missouri counties – Caldwell, Crawford, Iron, Oregon, Shannon, and Shelby – did not have a single resident primary care physician. Data is representative of provider's home residence; practice location information is not available.



Source: Medical facility map data from Missouri Spatial Data Information Service, University of Missouri Columbia. Data available at http://msdis-archive.missouri.edu/archive/Missouri_Vector_Data/Health/
 Physician location data from US Dept of Health & Human Services, Health Resources & Services Administration. Area Health Resources File, 2017. Data available at <https://data.hrsa.gov/data/download>

The lack of robust markets on both the insurer and provider side contributes to significantly elevated premiums in rural areas of the state compared to core urban areas. Average monthly premiums in 2019 for Marketplace plans in counties outside of a Metropolitan Statistical Area (MSA) were \$819, compared to \$542 in St. Louis and \$603 in Kansas City.

| AVERAGE PREMIUMS IN 2019 | |
|-----------------------------|----------------------|
| MSA | Avg. Monthly Premium |
| Cape Girardeau | \$835 |
| Columbia | \$573 |
| Jefferson City | \$820 |
| Joplin | \$663 |
| Kansas City | \$603 |
| Springfield | \$667 |
| St. Joseph | \$803 |
| St. Louis | \$542 |
| Rural Counties (Not in MSA) | \$819 |

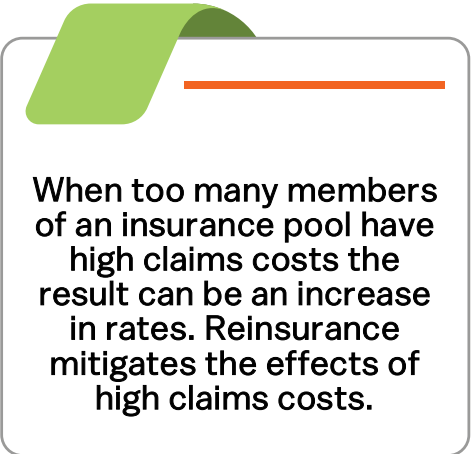
Source: Calculated by DCI from the U.S. Department of Health and Human Services, Public Use Enrollment File for 2019. Files available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/2019_Open_Enrollment

EXISTING STATE WAIVERS

As of the time of writing, 13 states have received federal approval for a Section 1332 Waiver. Seven states submitted a Section 1332 Waiver application only to subsequently withdraw them. The most common element of state waivers is the establishment of a reinsurance program to cover excess losses over and above some “attachment point,” or claims costs that exceed a monetary threshold. Because of the wide variety of ways that reinsurance programs have been structured in terms of attachment point, financing, and market segmentation (i.e. the types of claims that fall under the program), it is instructive to examine various state programs in some detail.

Reinsurance Programs

In broad terms, insurers use reinsurance to mitigate the effects of high claims costs. More specifically, in the context of health insurance, when too many members of a pool have high claims costs – such as transplants or cancer treatments – the result can be an increase in rates in subsequent years in order to account for these high claims. With the passage of the ACA, health insurers are prohibited from charging enrollees different premiums based on their health status, and may not deny coverage due to pre-existing health conditions. As a result, many individuals who had not previously had health insurance entered the market, and their relatively higher utilization of health services led to increased upward pressure on rates.



When too many members of an insurance pool have high claims costs the result can be an increase in rates. Reinsurance mitigates the effects of high claims costs.

The ACA created a temporary reinsurance program to reimburse insurers that incurred eligible high-cost claims. The program was financed by insurer contributions. A portion of claim costs above a specified threshold, up to a maximum, was assumed by the program. The program was designed to temporarily stabilize the market and provide some protection to insurers that incurred higher than expected costs. The temporary reinsurance program ended at the end of 2016. Some of the subsequent rate increases in following years were attributed to the end of the temporary reinsurance program.⁷ As a result, states sought to reintroduce a reinsurance mechanism through the Section 1332 Waiver process, which became available as an option in 2017.

Reinsurance programs require a waiver of Section 1312(c)(1) of the ACA, which requires that all members of a given market be treated as a single insurance or risk pool. The provision could otherwise require that any reinsurance payments to insurers be excluded when establishing the index rate. In addition, waiver applications generally include federal pass-through funding to offset the costs of the programs. States are eligible for federal pass-through funding to the extent that the waiver results in a reduction of costs incurred by the federal government. Generally, such cost reductions may accrue from a reduction in federal premium tax credits resulting from a decrease in overall rates in the individual market.

⁷ See, for example American Academy of Actuaries. “Issue Brief: Drivers of 2017 Health Insurance Premium Changes.” May, 2016. Available at <https://www.actuary.org/sites/default/files/files/publications/IB.Drivers5.15.pdf> The AAA projected the phase-out of the reinsurance program increased premiums by 4 and 7 percent in 2017.

Alaska – Health Condition-Specific Reinsurance

Alaska was the first state to successfully file a Section 1332 Waiver, which was approved in 2017 and became operational for the 2018 plan year. The waiver established the Alaska Reinsurance Program (ARP) as an excess insurer. The ARP was expected to lower premium tax credits incurred by the federal government by lowering overall premiums. Federal savings would accrue back to the state of Alaska in the form of “pass-through funding.”

The ARP covers all claims arising from individuals with 33 specified high-cost health conditions that were initially identified by actuarial analysis of claims data. Among the covered conditions are life-long central nervous system disorders, such as multiple sclerosis, Parkinson’s disease, and cerebral palsy; various severe cancers including cancers of the lung, brain, acute lymphoid leukemia and non-Hodgkin’s lymphomas; blood and immune disorders, including HIV / AIDS, hemophilia, and sickle-cell anemia; and acute organ failure such as advanced liver disease or end-stage renal disease, among other conditions.⁸

Essentially, Alaska created a bifurcated risk-pool by removing the highest-cost health conditions from the general individual market altogether. Both premiums and claims for such individuals are entirely ceded to the reinsurance program. The state provides additional program funding through general revenue. While program costs in 2018 were expected to approach \$60 million, federal pass-through funding offset all but \$1.5 million. The program has been largely successful in both decreasing premiums as well as modestly increasing enrollment.⁹

⁸ See Alaska Admin. Code tit. 8 § 31.500, available at <https://www.commerce.alaska.gov/web/Portals/11/Pub/ARP-Regulations.pdf>.

⁹ Schwab, Rachel, Emily Curran and Sabrina Corlette. Assessing the Effectiveness of State-Based Reinsurance: Case Studies of Three States’ Efforts to Bolster Their Individual Markets. Georgetown University Health Policy Institute. November, 2018.

Oregon, Minnesota & Colorado

These three states adopted a claims-based reinsurance program in which reinsurance covers a portion of claim costs for an individual that exceeds a monetary threshold (or “attachment point”). Unlike Alaska, in these states, reinsurance attaches regardless of the specific medical condition associated with the claims. A portion of costs exceeding a specified monetary threshold are paid for by reinsurance up to a maximum (the “cap”). Waiver applications from Oregon and Minnesota were approved in 2017, and the application from Colorado was approved in 2019 (see following table for more information).

Oregon established an attachment point of \$95,000. Once an insurer incurs \$95,000 in claims costs for a given member over the course of a year, reinsurance covers 50 percent of any additional claims costs up to \$1 million. The Minnesota program covers 80 percent of claim costs with an attachment point of \$50,000 and a cap of \$250,000. The Colorado reinsurance program assumes an average of 60 percent of the costs for claims between \$30,000 and \$400,000.

Colorado adopted a framework with three tiers which target the greatest premium reductions in the highest-cost areas of the state, whereby each tier is subject to different reinsurance reimbursement rates or coinsurance percentages.

| Tier (based on geographic rating areas) | Expected Premium Reduction, Mandated in Colorado Statute | Final Coinsurance Rates |
|---|--|-------------------------|
| Tier 1 | 30% - 35% | 45% |
| Tier 2 | 20% - 25% | 50% |
| Tier 3 | 15% - 20% | 80% |

For states that have received a Section 1332 Waiver to establish a reinsurance program, the following table summarizes reinsurance type, attachment points and caps, funding mechanisms and federal pass-through funding, and estimated premium impact of each program.

| Approved 1332 Waivers with Reinsurance Programs | | | | | | |
|---|---------------|--|--|--|--|--|
| State | Date approved | Program Type | Attachment Point | Cap | Coinsurance Amount | Funding in addition to federal pass-through funding |
| Alaska | 7/7/2017 | Condition Specific | N/A – all claims from individuals with specific conditions | N/A – all claims from individuals with specific conditions | 100% | General revenue / assessment on health insurers |
| Colorado | 7/31/2019 | Claims-based | \$30,000 | \$400,000 | Tiered based on geographic territory: 45%, 50% and 80% | Assessments on hospitals; premium tax |
| Delaware | 8/20/2019 | Claims-based | \$65,000 | \$215,000 | 75% | Insurer assessments |
| Maine | 7/30/2018 | Condition specific + prospective underwriting* | \$47,000 | \$77,000 | 90% in risk corridor, 100% on claims > \$77,000 | Assessments on health insurers and third party administrators. |
| Maryland | 8/22/2018 | Claims-based | To be determined | \$250,000 | 80% | Assessment on health insurers and Medicaid Managed Care |
| Minnesota | 9/22/2017 | Claims-based | \$50,000 | \$250,000 | 80% | General Revenue |
| Montana | 8/16/2019 | Claims-based | \$40,000 | \$101,750 | 60% | 1.2% on health insurance market |
| New Jersey | 8/16/2018 | Claims-based | \$40,000 | \$215,000 | 60% | Penalties from state individual mandate / general revenue |

| Approved 1332 Waivers with Reinsurance Programs | | | | | | |
|---|---------------|--------------|------------------|-------------|--------------------|--|
| State | Date approved | Program Type | Attachment Point | Cap | Coinsurance Amount | Funding in addition to federal pass-through funding |
| North Dakota | 7/31/2019 | Claims-based | \$100,000 | \$1 million | 75% | Assessments on group health insurance |
| Oregon | 10/18/2017 | Claims-based | \$95,000 | \$1 million | 50% | 1.5% assessment on major medical premium |
| Rhode Island | 8/26/2019 | Claims-based | \$40,000 | \$97,000 | 50% | Penalties from state individual mandate requiring coverage |
| Wisconsin | 7/29/2018 | Claims-based | \$50,000 | \$250,000 | 50% | General fund |

*Maine's reinsurance program automatically covers individuals with specified medical conditions, but also allows insurers to prospectively select members based on underwriting. Reinsurance covers excess claims (above the attachment point) for these individuals.

<https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Maine-fact-sheet.pdf>

Source: Kaiser Family Foundation, available at <https://www.kff.org/health-reform/fact-sheet/tracking-section-1332-state-innovation-waivers/>

Very few individuals in Missouri (or elsewhere) incur claims that exceed the lowest attachment point identified above (\$30,000 / year). Based on 2013-2015 claims data available to DCI, over 97 percent of claimants for one large insurer had total annual claims less than \$30,000 (excluding individuals who had no claims in a given year). Only 0.4 percent of claimants incurred costs exceeding \$100,000 in the space of a year (i.e. summing the final four columns in the table below).

However, the 97.5 percent of claimants with total annual claims less than \$30,000 account for roughly 60 percent total claim costs, and only 59.6 percent in 2015. During 2015, the 2.1 percent of claimants with annual claim costs of \$30,000-\$99,999 accounted for 23.3 percent of total claim payments, while the 0.4 percent of claimants with annual claims exceeding \$100,000 accounted for $(9.0 + 5.9 + 1.4 + 0.8) = 17.1$ percent of claim payments.

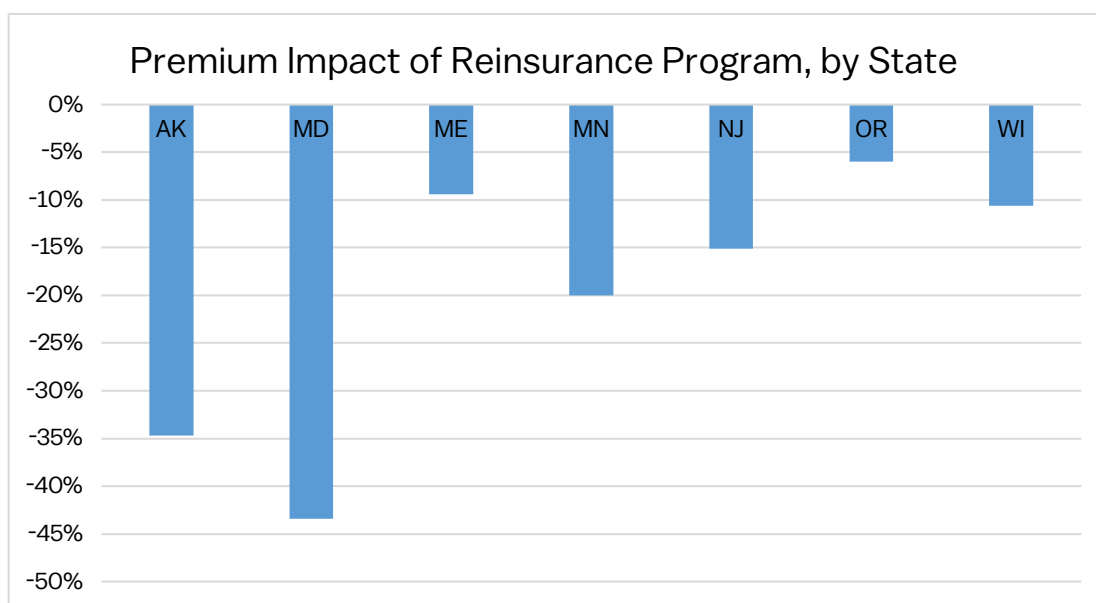
| % of Total Claimants by Total Annual Payments per Claimant | | | | | | | |
|--|--------|----------------|---------------|----------------|-----------------|----------------------|------------------|
| Year | Total | Less and \$30k | \$30k - \$99k | \$100k- \$199k | \$200k - \$500k | \$500k - \$1 Million | Over \$1 Million |
| 2013 | 100.0% | 97.8% | 1.9% | 0.3% | 0.1% | 0.0% | 0.0% |
| 2014 | 100.0% | 97.6% | 2.0% | 0.3% | 0.0% | 0.0% | 0.0% |
| 2015 | 100.0% | 97.5% | 2.1% | 0.3% | 0.1% | 0.0% | 0.0% |

| % of Total Claim Payment Amounts by Total Annual Payments per Claimant | | | | | | | |
|--|--------|----------------|---------------|----------------|-----------------|----------------------|------------------|
| Year | Total | Less and \$30k | \$30k - \$99k | \$100k- \$199k | \$200k - \$500k | \$500k - \$1 Million | Over \$1 Million |
| 2013 | 100.0% | 62.9% | 21.7% | 8.1% | 4.8% | 1.4% | 1.1% |
| 2014 | 100.0% | 61.1% | 21.8% | 9.2% | 5.0% | 1.6% | 1.3% |
| 2015 | 100.0% | 59.6% | 23.3% | 9.0% | 5.9% | 1.4% | 0.8% |

Source: Calculated by DCI

States that have enacted reinsurance programs have been largely successfully in reducing premium rates paid directly by insureds. Available estimates are presented in the following table.

| Estimated Impact of Recent State Reinsurance Programs | | | | |
|---|---|------------------------------|---------------|-----------------------------|
| State | Percent Change in Average Individual Market Premium | Federal Pass-Through Funding | State Portion | State's portion of cost (%) |
| AK | -34.7% | \$58.5M | \$1.5M | 2.5% |
| MN | -20.0% | \$131M | \$140M | 51.7% |
| OR | -6.0% | \$54.5M | \$35.5M | 39.4% |
| ME | -9.4% | \$65.3M | \$27.7M | 29.8% |
| MD | -43.4% | \$373.4M | \$88.6M | 19.2% |
| NJ | -15.1% | \$180.2M | \$143.5M | 44.3% |
| WI | -10.6% | \$127.7M | \$72.3M | 36.1% |



Source: Estimates produced by the actuarial firm Avalere, available at <https://avalere.com/press-releases/state-run-reinsurance-programs-reduce-aca-premiums-by-19-9-on-average>

ADDITIONAL STATE WAIVER CONCEPTS CONSIDERED

Essential Health Benefits

Under 2018 CMS guidance, Section 1332 Waivers allow states to count coverage that may be less comprehensive than ACA-compliant plans for purposes of satisfying the “coverage” guardrail. While states must make coverage that is at least as comprehensive and affordable as provided prior to a waiver *available*, there is no requirement that a state ensure that comparable numbers of persons are actually enrolled in such plans as opposed to other, less comprehensive coverage. States can meet the “number of people covered” by including those covered under less comprehensive plans. The 2018 guidance also afforded states greater flexibility with respect to the comprehensiveness standard itself, by permitting states to design essential health benefits. In some instances, federal subsidies may be made available to such plans, such as short-term plans.

Extending to states the ability to increase the rate of purchase of more affordable, if less comprehensive coverage, was an explicit component of the 2018 CMS guidance:

...a major disadvantage of the 2015 interpretation was that it deterred states from providing innovative coverage that, while potentially less comprehensive than coverage established under the PPACA, could have been better suited to consumer needs and potentially more affordable and attractive to a broad range of its residents...To avoid this effect of the 2015 guidance, this guidance focuses on the *availability* of comprehensive coverage.¹⁰

In addition, states may seek to waive the eligibility requirements for “catastrophic plans,” which offer high out-of-pocket expenses. Currently, catastrophic plans are available for individuals under age 30, or those over age 30 who meet income or financial hardship criteria. Catastrophic plans are not eligible for federal subsidies, and they are not eligible under IRS rules for use with a health savings account.

Catastrophic plans have not proven popular with consumers, at least as currently structured. During 2018, only 3,233 such policies were issued in Missouri’s individual market.¹¹

CMS has indicated that states may be able to waive eligibility requirements for catastrophic plans, as well as make subsidies available to defray the cost of coverage, or provide funding for dedicated consumer accounts.¹² However, in making less-comprehensive coverage options available, states must meet the guardrail mandating access to coverage at least as comprehensive and affordable as existed prior to a Section 1322 Waiver.


¹⁰ CMS – 9936-NC: State Relief and Empowerment Waivers. October 22, 2018, p. 10. Guidance, available at <https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-23182.pdf>

¹¹ Calculated by DCI, from Market Conduct Annual Statement data, submitted by insurers.

¹² CMS. Fact Sheet: State Empowerment and Relief Waiver Concepts. November 29, 2018. Available at <https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Waiver-Concepts-Fact-Sheet.pdf>

Standardized Plans

The Task Force discussed market improvements that may be possible through greater plan standardization. While the ACA requires all metal-level plans to cover certain “essential health benefits,” and the metal levels (bronze, silver, gold, platinum) effectuate required “actuarial value” levels, there are still significant discrepancies within these broad categories. Actuarial value targets prescribe the expected proportion of overall health costs that will be covered by the plan, *when such costs are averaged over the entire coverage pool*. For any specific individuals, total out-of-pocket costs will vary, as will available coverages under each given policy. Consumers can face a daunting number of confusing choices even accounting for the standard metal categories and the broad minimum required benefits under the ACA. A recent study published in *Health Affairs* found that “...more than 60 percent of those targeted by the health insurance exchange struggle with understanding key health insurance concepts,” raising questions about whether individuals possess the ability to properly evaluate trade-offs between different plan designs.¹³



A recent study published in *Health Affairs* found that “...more than 60 percent of those targeted by the health insurance exchange struggle with understanding key health insurance concepts.”

¹³ Long, Sharon K. et. al. 2014. The health reform monitoring survey: Addressing data gaps to provide timely insights into the Affordable Care Act. *Health Affairs*. 33: 161-167.

An example of what consumers face when shopping for health insurance through Healthcare.gov is below. While just two plans are shown, for this particular consumer in Jackson County, Missouri, 41 different plan options are available. Most of those plans only differ as to the deductibles and out of pocket maximums. Cost-sharing information isn't easy to see and the cost-sharing concepts aren't familiar to most consumers.

41 plans available
Sort by Premium

Monthly premium

\$464.60

Including a \$0.00 tax credit

[Filter Plans](#)

Cigna Healthcare

[Cigna Connect 7000](#)

Bronze | EPO | Plan ID: 74483MO0040022

★★★★★

[Compare](#)

Deductible

\$7,000

Individual total

Out-of-pocket maximum

\$8,150

Individual total

Estimated total yearly costs

[Add](#)

Copayments / Coinsurance

| | | | |
|---|---|--|---|
| <p>Emergency room care</p> <p>50% Coinsurance after deductible</p> | <p>Generic drugs</p> <p>50% Coinsurance after deductible</p> | <p>Primary doctor</p> <p>\$60</p> | <p>Specialist doctor</p> <p>50% Coinsurance after deductible</p> |
|---|---|--|---|

Plan features

- ✗ Adult Dental
- ✗ Child Dental

[Add Your Medical Providers](#)

Add your medical providers and we'll show you which plans cover them

[Add Your Prescription Drugs](#)

Add your prescription drugs and we'll show you which plans cover them

[Plan Details](#)

[Enroll](#)

Monthly premium

\$465.39

Including a \$0.00 tax credit

[Filter Plans](#)

Oscar Insurance Company

[Classic Bronze \(Free 24/7 Telemedicine + Free Preventive Care\)](#)

Bronze | EPO | Plan ID: 69512MO0010003

New plan - Not rated

[Compare](#)

Deductible

\$6,000

Individual total

Out-of-pocket maximum

\$8,150

Individual total

Estimated total yearly costs

[Add](#)

Copayments / Coinsurance

| | | | |
|---|--|---|---|
| <p>Emergency room care</p> <p>50% Coinsurance after deductible</p> | <p>Generic drugs</p> <p>\$3</p> | <p>Primary doctor</p> <p>\$50/50% Coinsurance after deductible</p> | <p>Specialist doctor</p> <p>50% Coinsurance after deductible</p> |
|---|--|---|---|

Plan features

- ✗ Adult Dental
- ✓ Child Dental

[Add Your Medical Providers](#)

Add your medical providers and we'll show you which plans cover

[Add Your Prescription Drugs](#)

Add your prescription drugs and we'll show you which plans cover

[Plan Details](#)


[Enroll](#)

Many states with a state-based exchange, as well as the Federal Exchange in plan years 2017 and 2018, attempted to promote greater uniformity between plans by adopting standardized benefits and cost-sharing. Such standardization was thought to facilitate comparison shopping, so that consumers could focus less on complex benefit features of plans and more on price and network quality. Nearly all states that adopted a standardized plan also permitted insurers to sell non-standardized plans so as not to stifle innovation.

Proposition E (Section 376.1186 RSMo.) was adopted by referendum on the November 6, 2012. The measure prohibits the establishment, creation or operation of a health insurance exchange in Missouri, unless expressly authorized by the Missouri General Assembly. It also prohibits state agencies from providing assistance or resources of any kind with regard to the operation of a federally facilitated marketplace. Any Section 1332 Waiver concepts that would entail any administrative functions of the federally facilitated marketplace (such as Qualified Health Plan certification or tax credit computation) would require express legislative authorization for the DCI or any other state agency to implement.

Separate High Risk Pool

Prior to the ACA, insurers exercised considerable discretion in making decisions about who was eligible for coverage, under what conditions, and at what price. Individuals with costly pre-existing conditions often were unable to obtain coverage in the individual market due to insurers' underwriting decisions. In instances where they were able to obtain coverage, premiums were often unaffordable. In addition, many insurers would exclude coverage for medical costs related to a pre-existing condition.



At its peak in 2011, the MHIP insured 4,048 individuals at an average annual premium of \$8,366 (or \$9,127 in 2018 dollars). In turn, the average annual medical costs per enrollee totaled \$12,362.

In such an environment, many states established high risk pools to provide access to coverage for individuals with costly medical conditions who were unable to obtain coverage in the private market. Missouri established such a pool in 1991, and the pool operated until the end of 2013 when the ACA guaranteed issue provisions and prohibitions on rating based on health status rendered it largely moot.

The Missouri Health Insurance Pool (MHIP) coverage included some limitations on pre-existing conditions, as well as a \$1 million lifetime limit on coverage. Enrollment was open to individuals who had been rejected for coverage by at least two insurers, or who were unable to obtain coverage at rates below the MHIP rate. By statute, the MHIP rate could not fall below 125 percent of a "standard market rate," nor could it exceed the market rate by more than 200 percent. Shortfalls were met by assessment on health insurers, though insurers who paid assessments could offset them in premium tax reductions.

At its peak in 2011, the MHIP insured 4,048 individuals at an average annual premium of \$8,366 (or \$9,127 in 2018 dollars). In turn, the average annual medical costs per enrollee totaled \$12,362. Over the entire period of operations, assessments to bridge the shortfall between premium and costs came to \$149,236,285.

Only a handful of states still operate high risk pools today. New Mexico still maintains a high risk pool that insures individuals who confronted significant barriers to obtaining private coverage prior to the ACA. While such individuals could presumably obtain coverage in the standard individual market today, many have chosen to remain in the pool. The pool continues to be subsidized by assessments on health insurers, who are given a 50 percent offset on premium taxes. In 2019, average monthly premiums for a plan with a \$500 deductible for a 40 year-old non-smoker ranged from \$555 to \$659, depending on area of residence.¹⁴ Additional premium discounts are available based on income. While the New Mexico pool remains in operation, enrollment has rapidly decreased since 2014, declining by nearly half from 4,721 to 2,390 in 2018.¹⁵

A full-blown health insurance high risk pool may be a viable extension of reinsurance programs described above. Care would have to be exercised to ensure that such things as eligibility criteria, underwriting practices, rating, and other features of a high risk pool can be accommodated within the Section 1332 Waiver process. As noted above, many

¹⁴ New Mexico Medical Insurance Pool rate tables, available at <https://nmhip.org/monthly-premiums-19/>

¹⁵ The New Mexico Medical Insurance Pool. Pool Stats, 2008. Available at <https://secureservercdn.net/198.71.233.109/hhg.3bb.myftpupload.com/wp-content/uploads/2019/09/The-Pool-Stats-201812-Final.pdf>

features of the ACA, such as guaranteed issue and the prohibition on rating based on health status, cannot be waived under the terms of the program. In addition, consideration should be given to how individuals insured in a high risk pool might remain eligible for federal premium subsidies. However, some reinsurance programs function similarly to a high risk pool. For example, Maine's reinsurance program covers 100 percent of the healthcare costs of individuals with specified medical conditions.

Pass-Through Funding

The Section 1332 Waiver provisions of the ACA allows states to obtain "pass-through" funding equal to the amount that federal expenditures are reduced due to the waiver. For example, many reinsurance programs have resulted in a reduction in overall premiums, and therefore a reduction in federal premium subsidies. In turn, the states are eligible to receive amounts equal to federal savings, which can then be used to fund Section 1332 Waiver programs.

Establish a State-Based Exchange

The ACA established the concept of health insurance exchanges which would perform various functions to facilitate the purchase of health insurance. Exchanges would serve as a convenient one-stop shopping forum allowing consumers to easily compare health plans and costs for approved plans (Qualified Health Plans, or QHPs) and apply for premium tax credits to defray the cost of coverage and cost-sharing reductions (CSRs) that reduce out-of-pocket expenses.

Currently, 12 states have established their own state-based exchanges. Twenty-eight states (including DC) rely on the Federally Facilitated Marketplace (FFM), while the remainder of states utilize a state-federal hybrid system which maintains the federal marketplace platform with the state assuming selected marketplace functions. Missouri is among those states that defaulted to the FFM.

The FFM currently levies an administrative fee equal to 3 percent of the premium of policies sold on the exchange to cover operational costs. States may be able to operate their own exchange for significantly less than 3 percent, with savings on administrative costs passed on to consumers in the form of lower premiums. In Missouri, it is estimated that the exchange fee on approximately \$1 billion in premium from exchange products (in 2018) amounts to \$35.8 million.¹⁶ Numerous third-party vendors claim an ability to operate an exchange for about half the federal costs. The Task Force heard from one such vendor, who suggested that economies of scale could be realized by utilizing IT architecture that already exists in some states.

¹⁶ Calculated by DCI, based on Market Conduct Annual Statement data, submitted by insurers.

Efforts to Broaden Market Participation

The Task Force also discussed a proposal that would require any insurer that participates in state programs (such as Medicaid Managed Care) to also offer coverage in the individual market, or broaden the geographic scope of operations within the state. As noted above, only eight insurers have any appreciable individual market premium in Missouri, and just four insurers control over 95 percent of the market. There is also no significant overlap between carriers currently offering individual market coverage in Missouri and carriers participating in the Medicaid Managed Care Program.

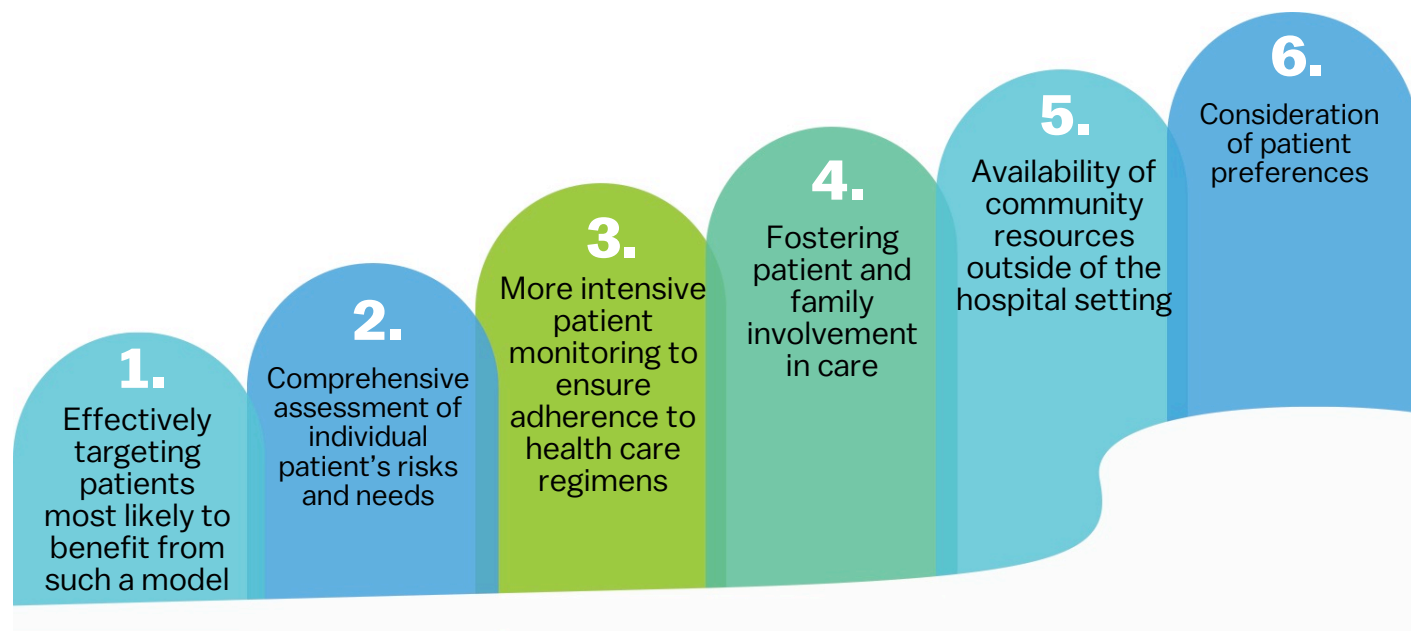
Complex Care Models

The Task Force spent considerable time analyzing possible improvements to the delivery of care to patients with health conditions that might benefit from more intensive management. Various “complex care” models strive to optimize health outcomes and reduce unnecessary utilization among the relatively small population with chronic high-cost conditions that account for a disproportionate share of health insurance claims costs. While a variety of complex care models exist, all involve cross-disciplinary approaches that seek to coordinate care across health care sectors, between the health sector and other sources of social support, and employ increased patient monitoring to encourage adherence to health care regimens. While services are more intensive, a reliance on primary care services is intended to reduce utilization of emergency rooms or inpatient treatment and potentially lower overall health costs for the target population. According to the National Center for Complex Health & Social Needs:

Some components of today’s complex care models, like home visits and community health worker programs, have existed for a long time, but it is only more recently that they have been combined with elements like data sharing, care coordination, inter-professional teaming, and risk stratification to become what we call complex care: care specifically designed to improve the wellbeing of people with complex health and social needs.¹⁷

¹⁷ The National Center for Complex Health and Social Needs. “Emerging Models of Complex Care: Cross-Sector Care, Community Based Care and More.” Available at <https://www.nationalcomplex.care/blog/emerging-models-of-complex-care-cross-sector-care-community-based-care-and-more/>

Analysis by the Commonwealth Fund identified several characteristics of complex care models that both improve care while reducing costs, among them:



However, the analysis noted that even well-designed models of complex care have had modest success, noting that barriers still remain. Among the most significant barrier is “...the lack of supportive financial incentives under fee-for-service reimbursement arrangements.”¹⁸ Other studies have also produced mixed results. One of the most rigorous employed a randomized controlled trial of “The Hotspotters Program” created by the Camden Coalition of Health Care Providers to improve care delivery for “super utilizers” of health care. Employing a randomized trial, in which patients with similar conditions were randomly assigned to either complex care or traditional models ensures that proper scientifically rigorous comparisons are possible. The analytical problem is that individual patient costs typically decline over time under traditional care, so it is uncertain on its face whether cost declines also observed under complex care represent an improvement to care or cost efficiency. The researchers found that while cost declines for each patient were on average significant for both complex and traditional care, they found no statistically significant differences in cost declines between the two approaches.¹⁹ Other studies have also found mixed results, with a few observing modest cost decreases in the 5 percent range. However, a few studies observed modest cost *increases* of a similar magnitude. As such, it appears that any potential efficiency gains are highly sensitive to program design and / or particular health conditions selected.


The Task Force discussed the potential of complex care delivery systems at length in numerous sessions. For example, the Task Force heard a presentation regarding various complex care innovations targeting elderly populations by Mercy Virtual Care. By adopting many aspects of the complex care models described above, as well as

¹⁸ McCarthy, Douglas, Jamie Ryan and Sarah Klein. 2015. Models of care for high-need, high-cost patients: An Evidence Synthesis. The Commonwealth Fund, October 29, 2015. Available at <https://www.commonwealthfund.org/publications/issue-briefs/2015/oct/models-care-high-need-high-cost-patients-evidence-synthesis>

¹⁹ Finkelstein, Amy, Annetta Zhou, Sarah Taubman and Joseph Doyle. 2020. Health care hotspotting – A Randomized, Controlled Trial. The New England Journal of Medicine. 382: 152-162.

capitalizing on modern data and virtual technologies, Mercy measured a decline in hospitalizations by 50 percent and a 30 percent overall cost reduction.²⁰

While health care providers are generally the primary drivers of health care innovations, the Task Force considered ways in which innovation could be influenced via the insurance mechanism by extending incentives to both patients and providers to adopt best practices for complex care. As part of the Task Force's work, the actuarial firm Wakely analyzed the prevalence and claims costs of high-cost patients within Missouri's individual insurance market. The analysis found that 22 percent of insureds had been treated for a complex condition, and that they accounted for nearly 80 percent of total claims costs.²¹ Overall, Wakely found that individuals without a diagnosed chronic condition had average monthly claims amounting to \$103, compared to \$702 for individuals with one chronic condition (15.2 percent of insureds), and \$2,646 for individuals with at least two chronic conditions (7.0 percent of insureds). Wakely's detailed analysis for selected conditions can be found in the appendix.



The analysis found that 22 percent of insureds had been treated for a complex condition, and that they accounted for nearly 80 percent of total claims costs.

The Task Force discussed at length ways in which insurance coverage could encourage health maintenance behaviors for individuals with chronic conditions, as well as various cost containment efforts. A two-pronged approach was most intensely considered, which involved:

1. Reducing or eliminating cost-sharing for individuals with specified high-cost health conditions, either for specified services or for all health care, to encourage optimal levels of maintenance or follow-up care; and
2. Incorporating a capped provider reimbursement schedule.

After significant discussion, the Task Force opted to not pursue a recommendation involving complex care. First, many insurers already have "complex care" systems in place for such conditions as diabetes and other high-cost ailments. Secondly, the development of such programs requires a much higher degree of medical expertise than was available to the Task Force.

Lastly, and perhaps most critical, analysis provided by Wakely demonstrated that a fee schedule lowering reimbursement rates to health care providers would be necessary to achieve any significant savings. The Task Force did not believe this would be feasible either politically or through obtaining approval by CMS in conjunction with a Section 1332 Waiver.

While the Task Force believes there may be significant merit to complex care models, including the potential to improve health care outcomes at lower cost, it ultimately decided to defer to others that might wish to pursue such programs.

²⁰ Again, care must be exercised in interpreting the results, as similar declines may also be observed under traditional care models, as noted above.

²¹ Wakely employed Hierarchical Condition Categories (HCCs) to identify patients with high-cost health conditions. HCCs were developed by CMS to assign risk scores to patients to predict costs. HCCs includes a broad swath of chronic high-cost conditions, such as various types of cancer, COPD, asthma, diabetes, and select mental health conditions such as depression, among other chronic conditions.

FINAL RECOMMENDATIONS

After considerable deliberation and discussion, the Task Force agreed on two final recommendations:

Establish a reinsurance program to cover excess claims of the most costly insureds, to be funded primarily with federal “pass-through” funding available via the Section 1332 Waiver process. To the extent pass-through funding is not sufficient to cover the excess claims, additional funding is required for this proposal. A variety of assessments were discussed by the Task Force, including assessments on health insurers as well as health care facilities (hospitals). Various funding scenarios are discussed below, including ways of structuring non-general revenue sources in a way that maximizes premium impact as well as federal funds.

Expand the eligibility criteria for catastrophic plans. Catastrophic plans are currently available to individuals aged 30 and under, as well as those that satisfy various “hardship” criteria. ACA subsidies are not available for catastrophic plans. The Task Force proposes to expand eligibility for catastrophic plans to all ages, but limited to those that lacked ACA-compliant coverage for at least one year prior to enrollment for those aged 31 and over. This proposal is designed to minimize any impact on the existing individual ACA market.

This section sets out details of each proposal as agreed to by the Task Force.

Catastrophic Plans


The ACA makes catastrophic plans available to individuals aged 30 and under, as well as older individuals that satisfy various financial or other hardship criteria. CMS endorsed an expansion of such plans via the release of “waiver concepts” designed to assist states in developing Section 1332 Waivers. While catastrophic plans come with a very high deductible, they do cover all essential health benefits and comply with additional consumer protections afforded by the ACA, such as maximum out-of-pocket limits. The plans also provide first-dollar coverage for preventative services as well as three physician visits annually. They are guaranteed issue for eligible individuals.

The Task Force proposes to expand the availability of these plans by expanding allowable hardship exemptions, and proposes an additional modification of the benefit design for new insureds:

1. Catastrophic plans would be made available to all age groups.
2. For those over age 30, enrollment in catastrophic plans would be limited to individuals who had either no prior coverage for the entire preceding year or who had coverage that was not ACA-compliant coverage (such as a short-term plan, but excluding catastrophic coverage itself). More than likely, this would be implemented as an additional “Hardship Exemption” for the State of Missouri.
3. The enrollment period for catastrophic plans would be limited to the Annual Open Enrollment Period.
4. Catastrophic plans would exclude coverage for non-generic medications.
5. New enrollees under the expanded eligibility criteria would constitute a separate risk pool, separate from the existing catastrophic plan pool.

The Task Force was mindful that the expansion of catastrophic coverage must meet the following criteria, in part due to public policy considerations and in part to satisfy the Section 1332 Waiver guardrails. First, the proposal is designed to limit migration of those already insured by an ACA-compliant plan with more complete coverage. It is intended to provide a low-cost alternative to those who have previously been priced out of the ACA-compliant market. Today, these individuals are either uninsured or have a short-term insurance policy. As older individuals have the highest risk of developing a condition which would render them ineligible for non-ACA coverage, this option could provide a long-term solution for this population. To

meet the objective of expanding coverage options without disrupting the current market, this plan targets the most persistently uninsured (those lacking ACA coverage for at least one year). The rationale is that decreasing uninsured rates is a worthy policy goal in itself, as identified in the Executive Order that directed the Task Force’s work. Secondly, the proposal is carefully crafted to minimize any impact on the existing individual insurance market.




This proposal provides a low-cost alternative to those who have previously been priced out of the ACA-compliant market. Today, these individuals are either uninsured or have a short-term insurance policy.

As such, the “no prior coverage” eligibility restriction is an essential component of this proposal. Without such a restriction, it is likely that some portion of current enrollees in the “metal tier” plans (i.e. gold, silver, etc) would migrate to catastrophic coverage. Even though catastrophic coverage is ineligible for subsidies, Wakely estimates that such a migration could still be substantial relative to the current size of the catastrophic pool (400 enrollees in 2019). In addition, given the nature of the coverage, it is likely those migrating to catastrophic plans would be on average healthier than the overall individual market. If so, migration would increase average costs for those enrolled in the metal tiers and exert upward pressure on premium. Not only is this undesirable from a public policy perspective, it would also run afoul of the Executive Order as well as the Section 1332 Waiver guardrails. As such, any waiver application lacking strong eligibility limits would almost certainly be rejected by CMS.

In addition, based upon analysis provided by Wakely, the Task Force recommends that enrollees over age 30, newly covered under this proposal, should be treated as a separate risk pool. Catastrophic plans are generally (but not always) less costly than are available metal-level plans. Under the ACA, insurers are allowed to apply a separate rating factor to catastrophic plans based on the morbidity of the enrollees. Given that the vast majority of enrollees in catastrophic plans are under 30, they tend to be significantly less costly to insure than is the overall individual market. Adding additional insureds over age 30 will very likely increase average claims costs, leading to premium increases for all enrollees. To minimize any potential premium impact on enrollees age 30 and under, any Section 1332 Waiver should ensure that new enrollees over age 30 are treated as a distinct risk class, subject to existing limitations on age-based rating.

To control costs, the Task Force recommends that the prescription medication benefit be limited to generics for the expanded eligibility group. Wakely presented information that prescription drugs constitute 29.9 percent of overall claims costs, while non-generic drugs constitute 23.6 percent of overall claims costs. While the Task Force sought to minimize coverage limitations, catastrophic coverage with generic-only coverage would still be a net benefit to new enrollees who either had no prior coverage or coverage outside of the ACA, which in many instances offers no coverage for prescription drugs.



Wakely presented information that prescription drugs constitute 29.9 percent of overall claims costs, while non-generic drugs constitute 23.6 percent of overall claims costs.

For example, the market for short-term coverage has grown significantly in Missouri, as it has in all states. Short-term policies can provide less coverage than catastrophic plans, so that such individuals will potentially increase their level of coverage by shifting to catastrophic plans - even with a reduction in pharmacy benefits.

Given that subsidies are not available for the catastrophic plan, expansion of the product will be much more sensitive to price. The Task Force carefully weighed the trade-offs between reducing uninsured rates and curtailing benefits, and believes that this single benefit reduction constitutes an overall better option.

To give a sense of the impact of a modified catastrophic plan would have on premiums, Wakely provided estimates of the potential monthly premiums in the charts below.

**Table 5: 2021 Estimated Monthly Premiums
Age 27 by Rating Area**

| Rating Area | Lowest Cost Bronze Plan | Scenario 1 Catastrophic Premium | Scenario 2 Catastrophic Premium |
|-------------|-------------------------|---------------------------------|---------------------------------|
| 1 | \$331.05 | \$261.73 | \$294.92 |
| 2 | \$486.48 | \$384.61 | \$433.37 |
| 3 | \$323.98 | \$256.14 | \$288.61 |
| 4 | \$331.79 | \$262.32 | \$295.57 |
| 5 | \$321.34 | \$254.06 | \$286.27 |
| 6 | \$262.01 | \$207.15 | \$233.41 |
| 7 | \$316.96 | \$250.59 | \$282.36 |
| 8 | \$334.02 | \$264.08 | \$297.56 |
| 9 | \$449.00 | \$354.98 | \$399.98 |
| 10 | \$449.15 | \$355.10 | \$400.12 |

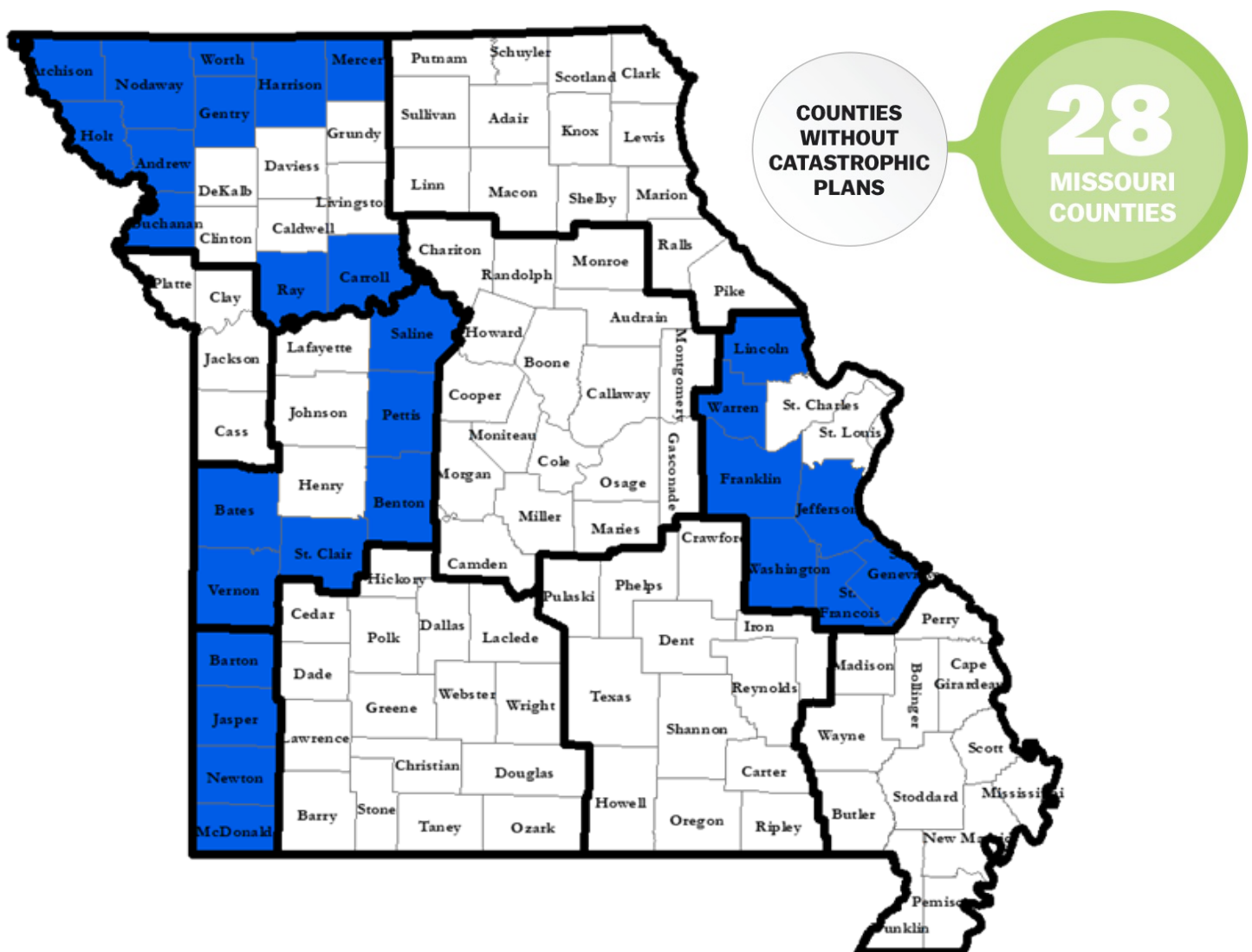
**Table 6: 2021 Estimated Monthly Premiums
Age 55 by Rating Area**

| Rating Area | Lowest Cost Bronze Plan | Scenario 1 Catastrophic Premium | Scenario 2 Catastrophic Premium |
|-------------|-------------------------|---------------------------------|---------------------------------|
| 1 | \$704.44 | \$556.94 | \$627.54 |
| 2 | \$1,035.15 | \$818.40 | \$922.15 |
| 3 | \$689.39 | \$545.04 | \$614.13 |
| 4 | \$706.00 | \$558.17 | \$628.93 |
| 5 | \$683.78 | \$540.60 | \$609.13 |
| 6 | \$557.53 | \$440.79 | \$496.67 |
| 7 | \$674.45 | \$533.23 | \$600.83 |
| 8 | \$710.76 | \$561.93 | \$633.17 |
| 9 | \$955.41 | \$755.36 | \$851.11 |
| 10 | \$955.73 | \$755.61 | \$851.40 |

Finally, the Task Force recommends that a Section 1332 Waiver application include a requirement that all insurers currently offering health insurance through ACA-compliant products in the individual market also be required to offer catastrophic plans in the same counties, regions or geographic rating areas that they are offering non-catastrophic plans. Catastrophic plans are currently unavailable in some areas of Missouri, including the four county region of Rating Area 7 in Southwest Missouri, which includes Joplin, as well as counties adjacent to St. Louis and St. Charles. Alternatively, another option for consideration would be to tie eligibility for the reinsurance program to those carriers who offer catastrophic plans throughout their service areas.

The map below shows those counties without catastrophic plans.

Counties Lacking a Catastrophic Insurance Plan




The Task Force believes that a carefully constructed proposal will minimize any impact on those currently insured by an ACA individual plan, as it is narrowly targeted to address the uninsured and underinsured population. This includes the eight percent of Missourians aged 31 to 64 that had no coverage for the entirety of 2018²² as well as individuals insured by short-term policies or other coverage that provides only a very limited range of benefits. It will provide a more affordable option for coverage to a narrowly defined population.

Reinsurance

As discussed previously, a large majority of claim costs are incurred by a minority of insureds who typically suffer from a variety of chronic health conditions. Wakely analysis largely reproduced estimates available from many other sources – roughly 20 percent of insureds account for 80 percent of costs. Reinsurance has been the most popular waiver concept sought among the states, given the potential to significantly impact rates. Depending on funding levels, the Task Force proposal is estimated to reduce premiums between 10 and 29 percent. Federal “pass-through” funds are expected to cover a majority of the costs arising from a reinsurance program.

A reinsurance mechanism would “reinsure” high-cost claims that fall within a defined range of costs, working to spread higher cost of claims amongst a larger pool of insurers and insureds. Primary insurers would be responsible for all claims costs up to a specified amount (the “attachment point”). Reinsurance covers a portion of expenses above the attachment point (“coinsurance”), up to a ceiling above which all costs revert back to the primary insurer. For example, a reinsurance program might specify an attachment point of \$50,000 and a ceiling of \$150,000. Primary insurers could be reimbursed for amounts between these points at a set coinsurance rate for example, 50 percent or less.



Reinsurance programs can also help states where insurers withdraw from their markets. Such programs offer insurers incentives to come back into the market by offsetting some of the costs associated with high-risk patients. These programs can also result in reductions in health insurance premium payments.

**- National Conference of
State Legislatures**

The Section 1332 Waiver makes any savings that accrue to federal expenditures via reinsurance available as pass-through funds to the states. Reinsurance could significantly reduce premiums through a draw-down of federal subsidies that would otherwise be used for Advanced Premium Tax Credits (APTC). Pass-through funds will then be used to offset high-cost claims. Most states that have implemented reinsurance mechanisms have contributed additional funding to further lower premiums which, in turn, draws down more federal funds.

²² Based on the 2019 Current Population Survey (Annual Socio-Economic Supplement).

Wakely Table 3: Reinsurance Program Impacts by Assessment Scenario

| | Scenario 1 Health Insurance Assessment (.90%) | Scenario 2 Accident & Health Assessment (Excluding LTC and Med Supp) (.65%) | Scenario 3 Accident & Health & Hospital Assessment (.3% & .025%) | Scenario 4 Accident & Health & Hospital Assessment (.3% & .01%) |
|---|--|---|---|--|
| Total Program Funding (Millions) | \$279.3 to \$329.4 | \$273.8 to \$320.6 | \$143.8 to \$169.3 | \$121.3 to \$143.7 |
| Federal Pass-Through Funding (Millions) | \$221.5 to \$271.7 | \$219.0 to \$265.8 | \$112.6 to \$138.1 | \$93.6 to \$116.1 |
| State Funding via Assessment (Millions) | \$57.7 | \$54.8 | \$31.2 | \$27.7 |
| Federal Funding Level (%) | 79.3% to 82.5% | 80.0% to 82.9% | 78.3% to 81.6% | 77.2% to 80.8% |
| Individual Health Insurance Market Premium Impacts (%) | -29.0% to -21.7% | -28.4% to -21.5% | -15.0% to -11.3% | -12.7% to -9.5% |

Source: Wakely. "State of Missouri Health Insurance Innovation Task Force: Feasibility Study." January, 2020.

Wakely analyzed expected costs under a variety of scenarios. In its analysis, Wakely provided information on potential operational parameters – such as the attachment point for claims, the cap on claims, and the coinsurance amount for which health insurers would be responsible. This information was necessary to evaluate the potential impact of the various scenarios. However, based upon recommendations of Wakely and upon the experience of other states, the Task Force does not recommend specific operational parameters. The operational parameters will need to be revised based upon actual funding in the initial year and then adjusted on an annual basis thereafter to accommodate changing market conditions and to maximize premium impact. Specifically, the Task Force recommends legislation confer authority upon the DCI to define specific attachment points and coinsurance amounts subject to these broad parameters:

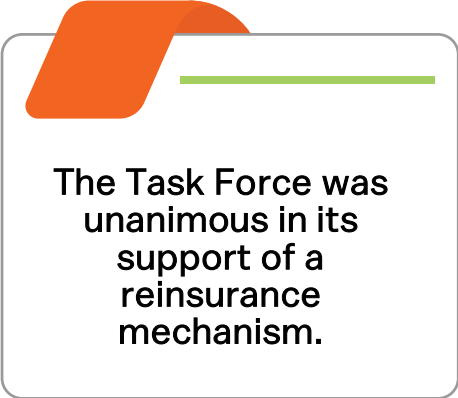
1. Minimize the variance of the impact of the program between insurers. Ideally, no insurer should be disproportionately impacted by a reinsurance program so as to minimize disruption of the existing market;
2. Maximize federal pass-through funding; and
3. Maximize premium reduction.

Funding

The Task Force spent a considerable amount of time discussing a variety of funding mechanisms. While the possibility of funding via general revenue was discussed, such an approach was not under consideration because of the Executive Order that governed the work of the Task Force – namely, proposals should have no impact on general revenue.

The Task Force was unanimous in its support of a reinsurance mechanism.²³ The focus of the discussions centered around the funding sources and with the objective of being equitable between the various parties.

The Task Force was cognizant of the impact of an assessment upon just the fully insured major medical health plans. A narrow assessment upon only major medical plans would have the unintended consequence of incentivizing small and large employers to exit the fully-insured market and self-fund their health benefit plans. This would result in multiple negative impacts upon the market, specifically on the individual market.



The Task Force was unanimous in its support of a reinsurance mechanism.

The Task Force deliberated extensively on the different funding options. Health insurers (both members of the Task Force and non-members²⁴) were clear in their support of the reinsurance mechanism and were open to an assessment upon health insurers' written premiums. However, it was clear there was a strong division between the health insurers and health care facilities as to the inclusion of a facility (hospital) assessment.

Hospital representatives were supportive of the reinsurance concept; however, they voiced concern over additional financial obligations, including Medicare reimbursement reductions, disproportionately impacting small and rural hospitals. Insurer representatives suggested implementing a tiered assessment, to protect small and rural hospitals from any additional financial hardships, while still ensuring an equitable burden between insurers and hospitals. A suggestion of a financial hardship exemption was also raised as a potential compromise. Despite continued conversations covering a number of tiered funding structures, hospital representatives would not agree to or support any reinsurance funding that included a hospital assessment.

However, health insurers (members of the Task Force and non-members) all agreed that the reinsurance program is crucial to stabilizing the market and lowering premiums. Health insurers would be willing to fund an assessment for the reinsurance program with participation from the hospitals.

Again, the Task Force is recommending the State pursue a reinsurance program. As there was not unanimity on a single funding methodology, the Task Force's report includes four (4) different funding options for further consideration. Each of these funding options has a detailed analysis done by Wakely identifying its impact. For the first year, each of the funding options provided as an illustration in this report is estimated to decrease individual market insurance premiums by at least 10 percent, and could result in premium decreases up to 29 percent or more.

²³ One Task Force member supported the concept of reinsurance, but only in conjunction with additional concepts.

²⁴ One insurer was not supportive of any assessment that only includes health insurance companies.

The Task Force recommends Missouri seek a Section 1332 Waiver to implement a reinsurance program.

The funding explored on behalf of the Task Force include two (2) options that reflect an assessment only upon Accident and Health insurers. The other two (2) options include a shared burden between insurers and hospitals, with assessments upon Accident and Health insurers and upon hospital net revenues.

The assessment scenarios considered by the Task Force and included within this recommendation are:

- Scenario 1: 0.9 percent premium assessment on all comprehensive health insurance premiums
- Scenario 2: 0.65 percent premium assessment on all accident and health insurance premiums, excluding Medicare Supplement and Long-Term Care.
- Scenario 3: 0.3 percent premium assessment on all commercial accident and health premiums, excluding Medicare Supplement and Long-Term Care, and a 0.025 percent assessment on net revenues for all hospitals in the State of Missouri.
- Scenario 4: 0.3 percent premium assessment on all commercial accident and health premiums, excluding Medicare Supplement and Long-Term Care, and a 0.01 percent assessment on net revenues for all hospitals in the State of Missouri.

| Assessment scenario | Assessment on insurer premium | Assessment on Hospital Revenue | Estimated Total Assessment | Estimated premium impact |
|---------------------|-------------------------------|--------------------------------|----------------------------|--------------------------|
| Scenario 1 | \$57,740,000 | \$0 | \$57,740,000 | -29% to -21.7% |
| Scenario 2 | \$54,790,000 | \$0 | \$54,790,000 | -28.4% to -21.5% |
| Scenario 3 | \$25,287,000 | \$5,922,000 | \$31,210,000 | -15% to -11.3% |
| Scenario 4 | \$25,287,000 | \$2,372,000 | \$27,660,000 | -12.7% to -9.5% |

Source: Wakely. "State of Missouri Health Insurance Innovation Task Force: Feasibility Study". January, 2020.

The Task Force was unable to reach a consensus regarding a single funding option. Therefore, a single funding mechanism is not being recommended by the Task Force in this report.

While the Task Force is recommending the state pursue a reinsurance program to reduce premiums for Missourians, a specific funding mechanism is not recommended by the Task Force in this report. Despite extended discussions, no compromise was made regarding a single funding option. Hospital representatives were unwilling to commit to any funding contribution. Hospital representatives stated hospitals have taken on additional financial obligations, including Medicare reimbursement reductions, which disproportionately impact small and rural hospitals. Hospital representatives also note that Missouri hospitals already pay provider taxes to fund Medicaid (MO HealthNet). Health insurers strongly believe that hospitals should be a part of any solution. Hospitals would benefit from an increase in the number of Missourians with

The Task Force recommends Missouri seek a Section 1332 Waiver to implement a reinsurance program, which could lower premiums by as much as 29 percent.

commercial health insurance, rather than relying on federal DSH payments to partially reimburse uncompensated care. Despite the lack of a compromise agreement, health insurers would be willing to fund an assessment for the reinsurance program with participation from the hospitals.

As a supplement to the Wakely analysis, and to assist continuing discussions on reinsurance funding, the Task Force has included in the Appendix to this report, a detailed breakdown of insurance premiums as of 2018 (Appendix A). The Task Force has also included a detailed breakdown of all hospital net revenues in the state (Appendix B).

Other Considerations

Enabling legislation should specify parameters for each of the following categories:

Administration – The DCI believes that significant savings can be achieved by administering the reinsurance program within the Department. Establishing an independent board to administer the program will entail significant start-up costs. The DCI possesses much of the existing infrastructure in place to immediately implement a reinsurance program. Assessments on entities other than insurers should be administered by another relevant department, such as the Department of Social Services, which already performs similar functions.

Deficits and Surpluses – Legislation should specify how program deficits are treated. Specifically, the Task Force recommends that costs exceeding available reinsurance funds should revert back to the primary insurer, as opposed to levying additional assessments. Surpluses should be retained as a reserve for potential future costs.

Legal Authority – Legislation should extend to each administering agent the appropriate legal authority necessary to properly administer the program, including the collection of necessary claims or other data that might be required, as well as establishing an independent fund separate from general revenue.

Geographic or Tiered Reinsurance Program – Because of time constraints, the Task Force did not fully analyze or evaluate a geographic or tiered reinsurance program. The Task Force does want to specifically highlight the potential inclusion of a geographic or tiered approach in administering the reinsurance program. Such a program could be designed to offer a greater level of premium relief and stability throughout the rural areas of the state.

CONCLUSION

Through fourteen (14) public meetings, starting August 8, 2019 and continuing through January 30, 2020, the Task Force members discussed and considered a wide variety of concepts to address the unique Missouri challenges it identified. This Final Report is the culmination of those efforts, reflecting the Task Force's final recommendation to Governor Michael L. Parson.

The Task Force recommends the State of Missouri pursue a Section 1332 Waiver. The Task Force recommends the Section 1332 Waiver specifically include two (2) concepts: first, a limited expansion of catastrophic plans and second, the creation of a reinsurance program.

The expansion of catastrophic health plans will provide Missourians currently without insurance another lower-cost coverage option to choose from. In particular, expanding catastrophic plan availability will provide another lower cost health coverage option for Missourians who may have been priced out of the current health insurance market. Producer representatives on the Task Force noted this will be a particularly attractive option to those aged 45-64. It will also benefit those individuals wanting to leave employment with health coverage to start their own business. These individuals need the certainty of guaranteed issue coverage that is affordable in order to make that type of life change.

Reinsurance programs are a proven private sector tool in managing difficult insurance markets. Twelve (12) states have implemented a reinsurance program and at least three (3) other states are contemplating or are in the process of obtaining approval to operate a reinsurance program through a Section 1332 Waiver. A reinsurance program has been the single most commonly used tool by states to lower premiums in the individual health insurance markets.

A reinsurance program will further stabilize the individual health insurance market. A well-designed reinsurance mechanism can reduce the volatility of high-cost claims and, in turn, lower insurance premiums. A more stable market will encourage insurers to expand their service areas into the rural parts of the state, increasing access to more affordable insurance coverage. Lower health insurance premiums that are more affordable for the average Missourian will also help lower the uninsured rate in the State. A lower uninsured rate will benefit the State, but it will also benefit health care facilities and hospitals by reducing the level of uncompensated care.

The Task Force believes that, together, these two recommendations meet the objectives the Task Force identified early on. Likewise, they meet the objectives given to the Task Force under the Executive Order.

Appendix A: Insurer Written Premiums (2018) and Covered Lives

Appendix A: Assessable Premium

| Assessable Accident & Health Premium, by Line Missouri Business | | |
|--|------------------------|------------------------------|
| Line | Premium Written | Covered Lives Year-End |
| Comprehensive - Individual | \$1,815,103,972 | 243,617 |
| Comprehensive - Small Group | \$1,194,540,321 | 191,711 |
| Comprehensive - Large Group | \$3,404,146,257 | 715,964 |
| Subtotal | \$6,413,790,550 | 1,151,292 |
| Individual - Specified Disease | \$96,005,643 | 298,345 |
| Individual - Accident Only | \$63,522,542 | 400,485 |
| Individual - Disability Income | \$111,847,829 | 128,298 |
| Individual - Dental | \$36,160,572 | 99,065 |
| Individual - Limited Benefit | \$48,008,240 | 153,238 |
| Individual - Short Term Credit Disability | \$1,112,405 | 9,088 |
| Individual - Long Term Credit Disability | \$155,391 | 1,606 |
| Individual - Credit Unemployment | \$0 | 0 |
| Individual - Stop Loss | \$6,276,011 | 141,240 |
| Group - Specified Disease | \$34,833,470 | 208,254 |
| Group - Accident Only | \$110,230,122 | 6,402,141 |
| Group - Disability Income | \$315,434,996 | 1,317,747 |
| Group - Dental | \$275,533,543 | 750,182 |
| Group - Limited Benefit | \$225,795,125 | 3,794,715 |
| Group - Short Term Credit Disability | \$8,967,299 | 46,362 |
| Group - Long Term Credit Disability | \$2,439 | 21 |
| Group - Credit Unemployment | \$0 | 0 |
| Group - Stop Loss | \$493,705,878 | 1,222,812 |
| Total | \$8,241,382,055 | 16,124,891 |

| Comprehensive Major Medical Expense Missouri Business | | |
|--|------------------------|-------------------------------|
| Insurer Group | Premium, 2018 | Covered Lives, Year-End |
| American Intl Group | \$569,554 | 475 |
| American Natl Fin Group | \$179,561 | 42 |
| Anthem Inc Group | \$2,285,339,528 | 390,122 |
| BCBS Of KC Group | \$1,124,783,269 | 249,260 |
| Centene Corp Group | \$557,017,938 | 54,922 |
| Cigna Health Group | \$670,453,941 | 111,366 |
| CNA Ins Group | \$1,612 | 8 |
| Cox Ins Group | \$154,718,406 | 33,564 |
| CVS Group | \$368,966,623 | 66,395 |
| Guardian Life Group | \$2,674 | 9 |
| Humana Group | \$94,947,794 | 16,662 |
| Knights Of Columbus | \$1,774 | 1 |
| Shelter Ins Group | \$3,166,881 | 709 |
| Tokio Marine Holdings Inc Grp | \$220,526 | 232 |
| UnitedHealth Group | \$1,153,420,463 | 227,525 |
| Total | \$6,413,790,550 | 1,151,292 |

| Commercial Accident & Health, Excluding Medicare Supplement and Long Term Care Missouri Business | | |
|--|-----------------|----------------------------|
| Insurer Group | Premium, 2018 | Covered Lives, Year-End |
| 5 Star Life Insurance Company | \$591 | 2 |
| AAA Life Group | \$1,587,005 | 7,166 |
| Aegis Group | \$19,523 | 2,094 |
| Aegon Us Holding Group | \$15,818,013 | 326,978 |
| Aflac Group | \$112,677,920 | 483,670 |
| Alleghany Group | \$645,037 | 12 |
| Allianz Ins Group | \$3,534 | 19 |
| Allstate Ins Group | \$17,258,832 | 150,622 |
| Amalgamated Life Insurance Co | \$181,625 | 1,642 |
| American Enterprise Mutual Group | \$3,192,484 | 5,863 |
| American Family Ins Group | \$2,269 | 37 |
| American Fidelity Corp Group | \$16,226,212 | 40,129 |
| American Financial Group | \$7,030,874 | 6,617 |
| American Financial Security Life Insurance Company | \$175,050 | 507 |
| American Home Life Insurance Company | \$315 | 8 |
| American Intl Group | \$9,808,156 | 1,571,386 |
| American Natl Fin Group | \$1,313,178 | 2,812 |
| Ameriprise Fin Group | \$1,224,337 | 1,152 |
| Ameritas Mutual Holding Group | \$12,455,664 | 28,954 |
| Amex Assurance Company | \$456,131 | 525,876 |
| Amfirst Holdings Group | \$1,801,096 | 2,215 |
| Anthem Inc Group | \$2,366,741,134 | 762,138 |
| Apollo Global Mgmt Group | \$2,679,399 | 10,893 |
| Arch Ins Group | \$131,760 | 4,925 |
| Arkansas BCBS Group | \$815,366 | 5,216 |
| Assuranceamerica Corp Group | \$62,143 | 1,275 |
| Assurant Inc Group | \$28,444,254 | 86,990 |
| Assurity Group | \$2,128,869 | 6,237 |
| Atlanta Life Insurance Company | \$936 | 1 |
| Atlantic Amer. Group | \$157,623 | 269 |
| Auto Owners Group | \$61,519 | 75 |
| Automobile Club MI Group | \$34,825 | 503 |
| Axa Ins Group | \$2,127,130 | 3,401 |
| Axis Capital Group | \$1,741,323 | 45,087 |
| Baltimore Life Insurance Company | \$2,249 | 10 |
| Banner Life Group | \$71,403 | 504 |
| BCBS Of KC Group | \$1,164,749,401 | 373,485 |
| BCB S Of MI Group | \$14,725 | 69 |
| BCBS Of SC Group | \$16,481,663 | 19,623 |

| Commercial Accident & Health, Excluding Medicare Supplement and Long Term Care Missouri Business | | |
|--|---------------|----------------------------|
| Insurer Group | Premium, 2018 | Covered Lives, Year-End |
| BCS Ins Group | \$3,126,859 | 9,712 |
| Berkshire Hathaway Group | \$2,527,798 | 10,098 |
| Best Life And Health Insurance Company | \$864,780 | 2,526 |
| Boston Mutual Group | \$595,319 | 3,816 |
| Brighthouse Holdings Group | \$125,751 | 145 |
| Catholic Financial Life | \$646 | 6 |
| Centene Corp Group | \$557,017,938 | 54,922 |
| Central States Group | \$471,951 | 6,506 |
| China Minsheng Group | \$6,940,582 | 5,994 |
| Chubb Ltd Group | \$26,770,527 | 2,078,422 |
| Cigna Health Group | \$805,874,261 | 611,482 |
| Cincinnati Fin Group | \$41,793 | 30 |
| Citizens Group | \$200 | 1 |
| Citizens Security Life Ins Co | \$4,412,833 | 6,926 |
| CNA Ins Group | \$2,450 | 14 |
| CNO Financial Group | \$19,866,291 | 31,716 |
| Continental General Insurance Company | \$823,360 | 4,089 |
| Country Ins & Fin Serv Group | \$267,491 | 407 |
| Cox Ins Group | \$154,718,406 | 33,564 |
| Cuna Mutual Group | \$4,965,279 | 242,207 |
| CVS Group | \$442,153,457 | 267,333 |
| Dai-ichi Life Holdings Inc Group | \$302,208 | 238 |
| Delta Dental Of Ks Group | \$1,071,339 | 15,022 |
| Delta Dental Plan Of Il Group | \$581,733 | 1,744 |
| Delta Dental Plan Of Mo Group | \$2,443,707 | 37,088 |
| Dental Care Plus Inc | \$591,160 | 2,119 |
| Dental Economics Group | \$2,942,829 | 9,261 |
| Dentaquest Group | \$183,983 | 727 |
| Dentegra Group | \$4,181,618 | 6,308 |
| ECG Group | \$2,748 | 0 |
| EMC National Life Company | \$60,606 | 77 |
| Enterprise Investments Group | \$19,684 | 37 |
| Equitable Family Ins Co Group | \$1,414,312 | 1,957 |
| Everest Reins Holdings Group | \$4,375,743 | 15,701 |
| Fairfax Fin Group | \$11,173,417 | 48,274 |
| Farmers Ins Group | \$352 | 4 |
| Farmers Mutual Hail Ins Group | \$270 | 22 |
| Federal Life Insurance Company | \$987 | 47 |
| Federated Mutual Group | \$942,608 | 754 |

| Commercial Accident & Health, Excluding Medicare Supplement and Long Term Care Missouri Business | | |
|--|---------------|----------------------------|
| Insurer Group | Premium, 2018 | Covered Lives, Year-End |
| Fidelity Life Association A Legal Reserve Life Ins | \$5,188 | 62 |
| Fidelity Security Group | \$18,376,102 | 240,863 |
| Financial Holdings Group | \$17,124 | 43 |
| First Tower Group | \$931,268 | 8,125 |
| First Trinity Fin Group | \$1,815 | 118 |
| General Electric Group | \$385,996 | 5,168 |
| Geneva Holdings Inc Group | \$4,535,402 | 3,482 |
| GGC Group | \$276,469 | 597 |
| Global Atlantic Group | \$3,021 | 5 |
| Globe Life Inc Group | \$19,838,138 | 286,423 |
| Great West Group | \$799,395 | 630 |
| Guarantee Trust Group | \$11,123,886 | 15,959 |
| Guardian Life Group | \$70,685,385 | 482,388 |
| Hartford Fire & Casualty Group | \$43,685,047 | 281,908 |
| HCSC Group | \$2,487,309 | 14,869 |
| Heartland National Life Insurance | \$626,878 | 1,309 |
| Highmark Group | \$6,285,079 | 16,204 |
| Homeshield Capital Group | \$7,269,309 | 4,410 |
| Hopmeadow Holdings Group | \$543,285 | 2,703 |
| Horace Mann Group | \$18,692 | 116 |
| Horace Mann Group | \$2,163,991 | 7,860 |
| Houston Intl Ins Group | \$3,067,665 | 2,627 |
| Humana Group | \$124,226,853 | 108,754 |
| Illinois Mutual Life Insurance Co | \$1,429,508 | 4,163 |
| Independent Order Of Foresters The | \$85,144 | 301 |
| Indiana Farm Bureau Group | \$806 | 2 |
| Individual Assurance Company Life Health & Accident | -\$11,076 | 301 |
| Industrial Alliance Group | \$176 | 2 |
| Intact Financial Group | \$513,518 | 2,228 |
| Jackson Natl Group | \$262,680 | 528 |
| John Hancock Group | \$47,583 | 46 |
| Kaiser Foundation Group | \$671,793 | 106,758 |
| Kansas City Life Ins Group | \$5,701,020 | 23,630 |
| Kemper Corp Group | \$5,799,511 | 14,162 |
| Kentucky Natl Ins Group | \$96,564 | 402 |
| Knights Of Columbus | \$66,689 | 164 |
| Kuvare Group | \$12,512 | 23 |
| Langhorne Reinsurance (Arizona) Ltd | -\$635 | 0 |

| Commercial Accident & Health, Excluding Medicare Supplement and Long Term Care Missouri Business | | |
|--|---------------|----------------------------|
| Insurer Group | Premium, 2018 | Covered Lives, Year-End |
| Liberty Mutual Group | \$872,607 | 7,500 |
| Lincoln Heritage Life Insurance Co | \$28,153 | 221 |
| Lincoln Natl Group | \$45,388,913 | 258,771 |
| Manhattan Life Group | \$5,293,585 | 3,791 |
| Markel Corp Group | \$237,880 | 64,970 |
| Mass Mutual Life Ins Group | \$8,111,815 | 4,787 |
| Maximum Corp Group | \$741 | 2 |
| Meiji Yasuda Life Ins Group | \$35,891,357 | 168,993 |
| Metropolitan Group | \$93,418,999 | 537,422 |
| Michigan Farm Bureau Group | \$7,037 | 18 |
| Minnesota Mutual Group | \$12,620,224 | 145,918 |
| Missouri Farm Bureau Group | \$296,321 | 131,461 |
| Modern Woodmen Of America | \$78 | 4 |
| Munich Re Group | \$4,168,190 | 138,105 |
| Mutual Of America Life Insurance Co | \$46,917 | 5 |
| Mutual Of Omaha Group | \$22,391,572 | 522,590 |
| National Gen Group | \$3,910,858 | 4,728 |
| National Guardian Life Ins Group | \$8,662,745 | 70,334 |
| National Life Group | \$88,810 | 94 |
| National Western Life Group | \$48,939 | 905 |
| Nationwide Corp Group | \$6,743,499 | 8,564 |
| New Era Life Group | \$3,452,085 | 3,765 |
| New York Life Group | \$2,689,157 | 28,789 |
| Nippon Life Insurance Co Of America | \$3,461 | 60 |
| Northwestern Mutual Group | \$28,800,396 | 23,492 |
| Ohio Natl Life Group | \$570,637 | 358 |
| Old Republic Group | \$4,575 | 204 |
| Oneamerica Fin Partners Group | \$1,451,554 | 16,757 |
| Opticare Of Utah Inc | \$34,429 | 484 |
| Pan Amer Life Group | \$2,120,838 | 1,349 |
| Partnerre Group | \$1,928,558 | 0 |
| Pekin Ins Group | \$228,818 | 126 |
| Penn Mutual Group | \$7,846 | 34 |
| Physicians Mutual Group | \$3,334,877 | 8,258 |
| Plateau Group | \$156,320 | 1,585 |
| Primerica Group | \$23,768 | 20 |
| Principal Fin Group | \$43,091,097 | 150,014 |
| Prosperity Life Ins Group | \$20 | 0 |
| Prudential Of America Group | \$19,898,695 | 264,738 |

| Commercial Accident & Health, Excluding Medicare Supplement and Long Term Care Missouri Business | | |
|--|-----------------|----------------------------|
| Insurer Group | Premium, 2018 | Covered Lives, Year-End |
| QBE Ins Group | \$8,304,728 | 15,422 |
| Renaissance Health Service Corp Group | \$1,782,516 | 4,929 |
| Security Mutual Life Insurance Company Of New York | \$491 | 2 |
| Security Natl Group | \$798 | 25 |
| Sentry Ins Group | \$29,020 | 4 |
| Shelter Ins Group | \$3,219,668 | 785 |
| Slovene National Benefit Society | \$152 | 30 |
| Southland Natl Holding Group | \$50,519 | 161 |
| Starr Group | \$68,293 | 7,671 |
| State Farm Group | \$4,311,584 | 15,562 |
| State Mutual Insurance Company | \$3,322,028 | 4,325 |
| Sumitomo Life Ins Group | \$10,907,130 | 33,022 |
| Sun Life Assur Co Of Cn Group | \$57,703,459 | 202,580 |
| Swiss Re Group | \$8,318,097 | 31,110 |
| Travelers Protective Assn Of America | \$18,457 | 1,178 |
| Thrivent Financial for Lutherans | \$840,201 | 1,377 |
| Time Insurance Company | \$5,946,951 | 8,865 |
| Tiptree Fin Group | \$681,775 | 4,440 |
| Tokio Marine Holdings Inc Group | \$62,702,939 | 1,106,297 |
| Trustmark Mutual Holding Co Group | \$3,897,077 | 7,710 |
| Unified Life Insurance Company | \$983,155 | 371 |
| Union Labor Group | \$1,941,948 | 20,612 |
| United Commercial Travelers Of America | \$314,707 | 563 |
| United Heritage Mutual Group | \$730 | 4 |
| United Security Assurance Company Of Pennsylvania | \$23,782 | 23 |
| United Serv Automobile Assn Group | \$62,784 | 96 |
| UnitedHealth Group | \$1,258,782,045 | 538,350 |
| Universal Guaranty Life Insurance Co | \$492 | 4 |
| Unum Group | \$89,535,777 | 391,995 |
| Vision Benefits Group | \$2,661,352 | 51,383 |
| Vision Service Plan Group | \$107,601,255 | 1,040,632 |
| Voya Financial Group | \$25,132,437 | 161,942 |
| Warrior Invictus Holding Co Group | \$11,769 | 29 |
| Wells Fargo Group | \$3,905 | 0 |
| West Southern Group | \$15,225,323 | 81,553 |
| Wilton Re Group | \$210,402 | 576 |
| Wisconsin Physicians Service Ins Group | \$97,126 | 318 |

| Commercial Accident & Health, Excluding Medicare Supplement and Long Term Care Missouri Business | | |
|--|-----------------|----------------------------|
| Insurer Group | Premium, 2018 | Covered Lives, Year-End |
| Woodmen Of The World Life Insurance Society | \$31,075 | 112 |
| WR Berkley Corp Group | \$22,239,335 | 71,607 |
| Zurich Ins Group | \$6,199,154 | 122,652 |
| Total | \$8,241,382,055 | 16,122,508 |

Appendix B: Hospital/Facility Net Revenues (2018)

| PROVIDER NAME | PROVIDER TYPE | Total Revenue ²⁸ | Net Revenue ²⁹ |
|--|-----------------------|-----------------------------|---------------------------|
| Barnes-Jewish Hospital | Short Term Acute Care | \$ 5,992,621,750 | \$ 2,028,038,828 |
| Barnes-Jewish Hospital Psychiatric Support Center | Psychiatric | \$ 19,441,714 | \$ 7,046,204 |
| Barnes-Jewish Saint Peters Hospital | Short Term Acute Care | \$ 429,398,736 | \$ 130,677,403 |
| Barnes-Jewish West County Hospital | Short Term Acute Care | \$ 436,818,285 | \$ 130,741,656 |
| Bates County Memorial Hospital | Short Term Acute Care | \$ 106,236,427 | \$ 35,535,920 |
| Belton Regional Medical Center | Short Term Acute Care | \$ 509,524,640 | \$ 71,093,368 |
| Black River Medical Center | Short Term Acute Care | \$ 85,766,984 | \$ 20,389,528 |
| Boone Hospital Center | Short Term Acute Care | \$ 934,584,699 | \$ 286,835,732 |
| Bothwell Regional Health Center | Short Term Acute Care | \$ 329,286,120 | \$ 122,278,121 |
| Cameron Regional Medical Center | Short Term Acute Care | \$ 169,142,780 | \$ 56,688,258 |
| Capital Region Medical Center | Short Term Acute Care | \$ 547,719,984 | \$ 196,530,285 |
| Carroll County Memorial Hospital | Critical Access | \$ 49,779,562 | \$ 29,072,267 |
| Cass Regional Medical Center | Critical Access | \$ 226,389,711 | \$ 70,821,368 |
| Cedar County Memorial Hospital | Critical Access | \$ 22,467,048 | \$ 11,899,281 |
| Center For Behavioral Medicine | Psychiatric | \$ 18,759,715 | \$ 14,876,820 |
| Centerpoint Medical Center | Short Term Acute Care | \$ 2,023,311,716 | \$ 287,568,281 |
| CenterPointe Hospital | Psychiatric | \$ 76,249,025 | \$ 43,871,356 |
| Children's Mercy Adele Hall Campus | Childrens | \$ 2,571,432,594 | \$ 1,221,967,124 |
| Christian Hospital | Short Term Acute Care | \$ 1,093,892,978 | \$ 262,829,014 |

²⁸ Total Revenue: the sum of total hospital charges to all patients.

²⁹ Net Revenue: the amount the hospital actually collects from all payers, including self-pay patients.

| PROVIDER NAME | PROVIDER TYPE | Total Revenue ²⁸ | Net Revenue ²⁹ |
|---|-----------------------|-----------------------------|---------------------------|
| CHRISTUS Dubuis Hospital of Saint Louis | Long Term | \$ 23,606,457 | \$ 8,053,057 |
| Citizens Memorial Hospital | Short Term Acute Care | \$ 397,831,267 | \$ 136,633,642 |
| Community Hospital Fairfax | Critical Access | \$ 26,291,118 | \$ 18,383,818 |
| Cox Barton County Hospital | Critical Access | \$ 47,004,211 | \$ 17,513,855 |
| Cox Medical Center Branson | Short Term Acute Care | \$ 750,005,500 | \$ 187,285,709 |
| Cox Monett Hospital | Critical Access | \$ 120,979,432 | \$ 43,941,463 |
| Cox North Hospital | Short Term Acute Care | \$ 3,680,234,349 | \$ 1,072,148,235 |
| Ellett Memorial Hospital | Critical Access | \$ 10,219,492 | \$ 7,868,364 |
| Excelsior Springs Hospital | Critical Access | \$ 54,855,230 | \$ 24,758,538 |
| Fitzgibbon Hospital | Short Term Acute Care | \$ 128,981,841 | \$ 48,786,822 |
| Freeman Neosho Hospital | Critical Access | \$ 103,852,679 | \$ 25,863,808 |
| Freeman West | Short Term Acute Care | \$ 2,003,857,507 | \$ 480,837,479 |
| Fulton Medical Center | Short Term Acute Care | \$ 28,328,094 | \$ 11,071,905 |
| Fulton State Hospital | Psychiatric | \$ 113,986,488 | \$ 79,648,784 |
| Golden Valley Memorial Hospital | Short Term Acute Care | \$ 290,198,936 | \$ 100,017,648 |
| Hannibal Regional Hospital | Short Term Acute Care | \$ 426,902,729 | \$ 166,218,466 |
| Harrison County Community Hospital | Critical Access | \$ 33,946,240 | \$ 21,233,386 |
| Hawthorn Children's Psychiatric Hospital | Psychiatric | \$ - | \$ - |
| Hedrick Medical Center | Critical Access | \$ 117,750,473 | \$ 56,955,892 |
| Hermann Area District Hospital | Critical Access | \$ 32,269,382 | \$ 18,363,156 |
| I-70 Community Hospital | Critical Access | \$ 16,301,894 | \$ 7,494,566 |
| Iron County Medical Center | Critical Access | \$ 30,529,288 | \$ 13,282,879 |
| Kindred Hospital - Kansas City | Long Term | \$ 52,893,499 | \$ 15,730,243 |

| PROVIDER NAME | PROVIDER TYPE | Total Revenue ²⁸ | Net Revenue ²⁹ |
|--|-----------------------|-----------------------------|---------------------------|
| Kindred Hospital - Saint Louis | Long Term | \$ 144,541,731 | \$ 36,005,851 |
| Kindred Hospital - Saint Louis at Mercy | Long Term | \$ 76,058,436 | \$ 18,688,066 |
| Kindred Hospital Northland | Long Term | \$ 62,512,624 | \$ 17,469,533 |
| Kindred Hospital St. Louis at Mercy | Short Term Acute Care | \$ 31,955,639 | \$ 7,818,690 |
| Lafayette Regional Health Center | Critical Access | \$ 123,885,726 | \$ 29,954,638 |
| Lake Regional Health System | Short Term Acute Care | \$ 506,379,624 | \$ 158,981,582 |
| Lakeland Behavioral Health System | Psychiatric | \$ 92,727,453 | \$ 28,141,604 |
| Landmark Hospital of Cape Girardeau | Long Term | \$ 36,861,729 | \$ 10,620,927 |
| Landmark Hospital of Columbia | Long Term | \$ 41,475,184 | \$ 12,506,024 |
| | Rehabilitation | \$ 6,141,294 | \$ 1,916,259 |
| Landmark Hospital of Joplin | Long Term | \$ 35,227,835 | \$ 9,614,789 |
| Lee's Summit Medical Center | Short Term Acute Care | \$ 575,821,369 | \$ 103,539,569 |
| Liberty Hospital | Short Term Acute Care | \$ 668,915,727 | \$ 220,412,370 |
| Long Term Acute Care Hospital Mosaic Life Care at Saint Joseph | Long Term | \$ 30,232,759 | \$ 11,072,168 |
| Madison Medical Center | Critical Access | \$ 38,555,192 | \$ 17,739,089 |
| Mercy Hospital Aurora | Critical Access | \$ 51,338,072 | \$ 20,664,563 |
| Mercy Hospital Carthage | Critical Access | \$ 117,668,254 | \$ 46,009,973 |
| | Short Term Acute Care | \$ 97,221,741 | \$ 35,206,258 |
| Mercy Hospital Cassville | Critical Access | \$ 44,862,011 | \$ 16,418,042 |
| Mercy Hospital Jefferson | Short Term Acute Care | \$ 730,144,715 | \$ 184,674,416 |
| Mercy Hospital Joplin | Short Term Acute Care | \$ 912,377,013 | \$ 235,489,591 |
| Mercy Hospital Lebanon | Short Term Acute Care | \$ 276,396,220 | \$ 92,638,275 |

| PROVIDER NAME | PROVIDER TYPE | Total Revenue ²⁸ | Net Revenue ²⁹ |
|--|-----------------------|-----------------------------|---------------------------|
| Mercy Hospital Lincoln | Critical Access | \$ 101,412,490 | \$ 34,728,006 |
| Mercy Hospital Saint Louis | Short Term Acute Care | \$ 3,714,895,636 | \$ 1,097,480,237 |
| Mercy Hospital South | Short Term Acute Care | \$ 1,464,539,448 | \$ 461,808,621 |
| Mercy Hospital Springfield | Short Term Acute Care | \$ 3,643,462,116 | \$ 992,069,902 |
| Mercy Hospital Washington | Short Term Acute Care | \$ 816,722,891 | \$ 198,237,134 |
| Mercy McCune-Brooks Hospital | Critical Access | \$ 145,117,678 | \$ 66,744,609 |
| Mercy Rehabilitation Hospital Springfield | Rehabilitation | \$ 34,207,302 | \$ 23,906,009 |
| Mercy Rehabilitation Hospital St. Louis | Rehabilitation | \$ 65,090,120 | \$ 40,971,854 |
| Mercy St. Francis Hospital | Critical Access | \$ 30,718,376 | \$ 13,670,707 |
| Metropolitan Saint Louis Psychiatric Center | Psychiatric | \$ 18,690,588 | \$ 15,540,121 |
| Missouri Baptist Medical Center | Short Term Acute Care | \$ 1,768,843,034 | \$ 584,596,730 |
| Missouri Baptist Sullivan Hospital | Critical Access | \$ 168,636,059 | \$ 57,543,807 |
| | Short Term Acute Care | \$ 131,310,614 | \$ 48,298,025 |
| Missouri Delta Medical Center | Short Term Acute Care | \$ 339,832,595 | \$ 84,487,558 |
| Missouri Rehabilitation Center | Long Term | \$ 34,693,346 | \$ 8,709,766 |
| Moberly Regional Medical Center | Short Term Acute Care | \$ 229,498,586 | \$ 48,938,276 |
| Mosaic Life Care at St. Joseph Medical Center | Short Term Acute Care | \$ 1,286,622,993 | \$ 558,345,690 |
| Mosaic Medical Center - Maryville | Short Term Acute Care | \$ 115,565,295 | \$ 57,541,056 |
| Nevada Regional Medical Center | Short Term Acute Care | \$ 99,622,032 | \$ 36,155,946 |
| North Kansas City Hospital | Short Term Acute Care | \$ 1,752,626,583 | \$ 488,280,189 |

| PROVIDER NAME | PROVIDER TYPE | Total Revenue ²⁸ | Net Revenue ²⁹ |
|--|-----------------------|-----------------------------|---------------------------|
| Northeast Regional Medical Center | Short Term Acute Care | \$ 332,293,058 | \$ 71,992,701 |
| Northwest Medical Center | Critical Access | \$ 25,094,247 | \$ 16,709,710 |
| Northwest Missouri Psychiatric Rehabilitation Center | Psychiatric | \$ 27,743,594 | \$ 23,333,316 |
| Osage Beach Center for Cognitive Disorders | Psychiatric | \$ 8,050,454 | \$ 5,301,135 |
| Ozarks Community Hospital | Short Term Acute Care | \$ 166,630,806 | \$ 37,175,290 |
| Ozarks Medical Center | Short Term Acute Care | \$ 449,184,292 | \$ 165,940,330 |
| Parkland Health Center - Bonne Terre | Critical Access | \$ 327,602,728 | \$ 92,336,183 |
| Parkland Health Center - Farmington | Short Term Acute Care | \$ 327,602,728 | \$ 92,336,183 |
| Parkland Health Center - Weber Road | Short Term Acute Care | \$ 65,628,837 | \$ 8,890,700 |
| Peace Haven Association | Other | \$ 2,224,362 | \$ 2,201,389 |
| Pemiscot Memorial Main Hospital | Short Term Acute Care | \$ 84,052,528 | \$ 28,674,920 |
| Perry County Memorial Hospital | Critical Access | \$ 155,249,170 | \$ 63,533,333 |
| Pershing Memorial Hospital | Critical Access | \$ 29,803,148 | \$ 14,781,674 |
| Phelps Health Hospital | Short Term Acute Care | \$ 901,953,054 | \$ 228,549,878 |
| Pike County Memorial Hospital | Critical Access | \$ 38,358,250 | \$ 14,957,759 |
| Pinnacle Regional Hospital | Short Term Acute Care | \$ 38,956,472 | \$ 12,842,959 |
| Poplar Bluff Regional Medical Center - Oak Grove | Short Term Acute Care | \$ 1,502,951,009 | \$ 206,223,338 |
| Progress West Healthcare Center | Short Term Acute Care | \$ 218,750,244 | \$ 71,279,101 |
| Putnam County Memorial Hospital | Critical Access | \$ 42,720,473 | \$ 31,749,948 |

| PROVIDER NAME | PROVIDER TYPE | Total Revenue ²⁸ | Net Revenue ²⁹ |
|--|-----------------------|-----------------------------|---------------------------|
| Ranken Jordan Pediatric Bridge Hospital | Childrens | \$ 44,251,975 | \$ 29,193,901 |
| Ray County Memorial Hospital | Critical Access | \$ 54,322,237 | \$ 27,278,626 |
| Research Medical Center | Short Term Acute Care | \$ 3,169,050,112 | \$ 434,379,447 |
| Research Psychiatric Center | Psychiatric | \$ 98,208,630 | \$ 20,933,777 |
| Royal Oaks Hospital | Psychiatric | \$ 21,188,186 | \$ 5,764,052 |
| Rusk Rehabilitation Hospital | Rehabilitation | \$ 29,909,575 | \$ 18,246,094 |
| Sac-Osage Hospital | Short Term Acute Care | \$ 11,352,600 | \$ 5,365,233 |
| Saint Alexius Hospital - Broadway Campus | Short Term Acute Care | \$ 150,325,184 | \$ 43,354,017 |
| Saint Francis Medical Center | Short Term Acute Care | \$ 2,169,949,947 | \$ 491,267,439 |
| Saint Genevieve County Memorial Hospital | Critical Access | \$ 106,972,038 | \$ 44,074,889 |
| Saint Joseph Medical Center | Short Term Acute Care | \$ 714,628,776 | \$ 147,019,640 |
| Saint Louis Children's Hospital | Childrens | \$ 1,259,521,264 | \$ 668,900,214 |
| Saint Louis Psychiatric Rehabilitation Center | Psychiatric | \$ 38,266,284 | \$ 32,454,467 |
| Saint Luke's Cancer Institute | Short Term Acute Care | \$ 78,890,102 | \$ 22,066,682 |
| Saint Luke's Des Peres Hospital | Short Term Acute Care | \$ 419,540,337 | \$ 90,513,214 |
| Saint Luke's East Hospital | Short Term Acute Care | \$ 1,391,863,399 | \$ 265,624,679 |
| Saint Luke's Hospital | Short Term Acute Care | \$ 1,566,090,305 | \$ 511,883,000 |
| Saint Luke's Hospital of Kansas City | Short Term Acute Care | \$ 3,189,020,480 | \$ 754,915,657 |
| Saint Luke's Hospital of Kansas City Crittenton Children's Center | Psychiatric | \$ - | \$ - |
| Saint Luke's North Hospital - Smithville | Short Term Acute Care | \$ 656,435,280 | \$ 138,056,025 |

| PROVIDER NAME | PROVIDER TYPE | Total Revenue ²⁸ | Net Revenue ²⁹ |
|---|-----------------------|-----------------------------|---------------------------|
| Saint Luke's Rehabilitation Hospital | Rehabilitation | \$ 24,126,880 | \$ 12,908,784 |
| Saint Mary's Medical Center | Short Term Acute Care | \$ 497,518,997 | \$ 90,438,476 |
| Salem Memorial District Hospital | Critical Access | \$ 47,224,443 | \$ 20,567,939 |
| Samaritan Hospital | Critical Access | \$ 47,938,078 | \$ 23,294,446 |
| Scotland County Memorial Hospital | Critical Access | \$ 43,610,775 | \$ 20,246,252 |
| Select Speciality Hospital - Springfield | Long Term | \$ 50,597,388 | \$ 14,466,754 |
| Select Specialty Hospital - Saint Louis | Long Term | \$ 77,928,308 | \$ 24,206,794 |
| Select Specialty Hospital - Western Missouri | Long Term | \$ 49,044,388 | \$ 13,019,196 |
| Shriners Hospitals for Children - Saint Louis | Childrens | \$ - | \$ - |
| Signature Psychiatric Hospital | Psychiatric | \$ 40,973,148 | \$ 16,971,634 |
| Southeast Health Center of Reynolds | Critical Access | \$ 9,082,224 | \$ 4,127,041 |
| Southeast Health Center of Reynolds County | Critical Access | \$ 16,499,211 | \$ 10,495,804 |
| | Short Term Acute Care | \$ 11,349,075 | \$ 4,753,297 |
| Southeast Health Center of Ripley County | Short Term Acute Care | \$ 23,997,841 | \$ 7,428,989 |
| Southeast Health Center of Stoddard County | Short Term Acute Care | \$ 84,093,440 | \$ 28,693,845 |
| Southeast Hospital | Short Term Acute Care | \$ 1,113,506,119 | \$ 320,539,930 |
| Southeast Missouri Mental Health Center | Psychiatric | \$ 76,426,726 | \$ 57,917,615 |
| Southwest Missouri Psychiatric Rehabilitation Center | Psychiatric | \$ 4,110,026 | \$ 4,183,898 |

| PROVIDER NAME | PROVIDER TYPE | Total Revenue ²⁸ | Net Revenue ²⁹ |
|---|-----------------------|-----------------------------|---------------------------|
| SSM Health Saint Clare Hospital - Fenton | Short Term Acute Care | \$ 717,911,012 | \$ 202,285,342 |
| SSM Health Saint Joseph Hospital-Saint Charles | Short Term Acute Care | \$ 804,685,648 | \$ 232,562,696 |
| SSM Health DePaul Hospital - St. Louis | Short Term Acute Care | \$ 1,582,352,727 | \$ 447,671,654 |
| SSM Health Rehabilitation Richmond Heights | Rehabilitation | \$ 205,808,489 | \$ 88,197,605 |
| SSM Health Saint Joseph Hospital - Lake Saint Louis | Short Term Acute Care | \$ 688,537,253 | \$ 184,169,380 |
| SSM Health Saint Louis University Hospital | Short Term Acute Care | \$ 2,306,320,793 | \$ 525,138,394 |
| SSM Health Saint Mary's Hospital - Audrain | Short Term Acute Care | \$ 173,665,377 | \$ 59,057,412 |
| SSM Health Saint Mary's Hospital - Jefferson City | Short Term Acute Care | \$ 431,516,786 | \$ 160,690,512 |
| SSM Health Saint Mary's Hospital - Saint Louis | Short Term Acute Care | \$ 2,087,283,537 | \$ 679,859,799 |
| Sullivan County Memorial Hospital | Critical Access | \$ 13,610,928 | \$ 7,843,826 |
| Texas County Memorial Hospital | Short Term Acute Care | \$ 79,864,764 | \$ 31,075,807 |
| The Rehabilitation Institute of Saint Louis-Central West End | Rehabilitation | \$ 74,239,309 | \$ 42,802,576 |
| Truman Medical Center Hospital Hill | Short Term Acute Care | \$ 719,094,159 | \$ 366,831,602 |
| Truman Medical Center Lakewood | Short Term Acute Care | \$ 253,077,019 | \$ 138,714,676 |
| Twin Rivers Regional Medical Center | Short Term Acute Care | \$ 297,059,613 | \$ 44,397,730 |
| Two Rivers Psychiatric Hospital | Psychiatric | \$ 11,056 | \$ 209,555 |

| PROVIDER NAME | PROVIDER TYPE | Total Revenue ²⁸ | Net Revenue ²⁹ |
|-------------------------------------|-----------------------|-----------------------------|---------------------------|
| University of Missouri Hospital | Short Term Acute Care | \$ 2,862,223,204 | \$ 915,710,341 |
| Washington County Memorial Hospital | Critical Access | \$ 44,090,026 | \$ 20,763,083 |
| Western Missouri Medical Center | Short Term Acute Care | \$ 247,604,503 | \$ 96,824,642 |
| Wright Memorial Hospital | Critical Access | \$ 58,426,925 | \$ 30,698,844 |
| Grand Total | | \$ 80,577,105,064 | \$ 23,714,356,119 |

Appendix C: Public Comments

Public comments that were received by the Task Force in response to its Request for Information can be viewed on the Task Force Webpage:

healthinsurancetaskforce.mo.gov

Request for Information: <https://healthinsurancetaskforce.mo.gov/wp-content/uploads/2019/09/Request-for-Information-September-2019.pdf>

Public Comments: <https://healthinsurancetaskforce.mo.gov/public-comments/>

Appendix D: Presentations to the Task Force

This Appendix summarizes presentations made by outside parties to the Task Force.

August 8, 2019

Center for Consumer Information and Insurance Oversight (CCIIO), Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services, Randy Pate and Lena Rashid

- Representatives from CMS provided an overview of the Section 1332 Waiver process, discussing the guardrails, the application process, and the history of the program.
- CMS also provided an overview of its Section 1332 Waiver Concept papers as possible options for states to consider.
- CMS representatives suggested to the Task Force that as they begin their work, they identify the problem and then determine the policy solutions to address the problem through a Section 1332 Waiver. They also encouraged frequent communication between the DCI and CMS throughout the planning process.

August 22, 2019

Manatt Health Solutions and the Center for Health Insurance Reforms at Georgetown University, Joel Ario and Justin Giovanelli

- Mr. Ario and Mr. Giovanelli provided an overview of the Section 1332 Waiver process, outlined the Section 1332 Waivers that have been approved to date, and suggested some possible strategies to address the need for quality, affordable coverage, particularly in rural areas of the state.
- They suggested that the state's goal when applying for a waiver should be to determine what the state could do to make the risk pool more balanced.
- A variety of different funding mechanisms were discussed. Generally, the broader the funding mechanism, the more resources a state can marshal for a greater impact.
- Not all reforms would require Section 1332 Waivers.
- Other reform concepts would, in Missouri, require a significant change in policy and legislative action.

Horizon Government Affairs, J.P. Wieske

- Mr. Wieske shared his opinion that the individual market will become more and more important as more people move from traditional employment settings to working in the "gig economy." He also believes that new IRS rules related to Health Reimbursement Accounts will have an impact on the individual market.
- Mr. Wieske is a former regulator from Wisconsin, and discussed his experience as a regulator when Wisconsin applied for a Section 1332 Waiver.
- He noted that Wisconsin saw a significant reduction in carriers offering coverage through the Marketplace between 2016 and 2018, and the risk pool was getting worse and worse.
- Wisconsin's Section 1332 Waiver created a reinsurance program, with the goals of maintaining or expanding consumer choice, lowering the impact of premium increases, and stabilizing the individual market. Wisconsin's program is a \$200 million reinsurance program, and it has reduced premiums by 11 percent. One carrier has re-entered the market and others have expanded their service areas

- Mr. Wieske noted that reinsurance alone won't solve all of the problems in the market, and he encouraged the Task Force to consider a multi-pronged, multi-year approach.

GetInsured, Chini Krishnan and Paul Neutz

- Technology company facilitating several state-based exchange platforms
- Some options for Section 1332 Waivers are only possible on a state-based exchange platform, not on the federal platform currently utilized in Missouri.
- Converting to a state-based exchange may involve a savings of federal funds because the operational costs are lower due to technological advances, but would be a significant policy change in Missouri.

September 12, 2019

For the September 12th Task Force meeting, members were invited to make presentations highlighting policy options from the perspective of the groups and organizations the members represent. Presentations were made by Task Force members representing hospitals in the state and by the four insurance carrier representatives.

Comments included the following:

- Population health in Missouri is 38th in the country – below the national average. A key question that can influence policy decisions is whether as a state we want to pay for health or health care.
- Hospital utilization trends in Missouri could be improved, but a Section 1332 Waiver isn't needed to encourage the use of preventive care. High Deductible Health Plans could also be used to encourage the use of primary care and virtual visits.
- A reinsurance waiver is an important first step, but not the only step.
- It is important to remember that the target audience for the impact of a Section 1332 Waiver is individual purchasers of individual market coverage.
- Costs in rural counties are often higher because of a lack of competition for both health care providers and health carriers.
- Making significant changes to Essential Health Benefits likely won't make a big difference, but there may be some small changes that could be impactful.
- Complex coverage pools would offer an opportunity for reduced costs and better quality for those with high needs.

Idaho Department of Insurance, Director Dean Cameron

- The Idaho Department of Insurance submitted an application for a Section 1332 Waiver in July, 2019, seeking waivers to allow the state to expand eligibility for tax credits to Idahoans who purchase coverage that is not as rich in benefits as traditional Qualified Health Plans.
- The goal of the waiver is to increase private coverage options and consumer choice.
- While Idaho's waiver request has not been approved by CMS, Director Cameron commented that he was hopeful that the state could continue negotiating with CMS.

Colorado Department of Regulatory Agencies, Division of Insurance, Commissioner Michael Conway

- Commissioner Conway provided an overview of Colorado's Section 1332 Waiver program, which was approved earlier in 2019.
- The Colorado program is a reinsurance program that is tiered to provide the most support to the rural areas of the state with the highest costs.
- Colorado levied an assessment on hospitals and used some general fund money to pay for its portion of the reinsurance program.

September 26, 2019

New Mexico Medical Insurance Pool, Deborah Armstrong

- New Mexico's High Risk Pool was created in 1987. It is one of a small handful of high risk pools still operating. It currently has approximately 2500 members
- The pool has remained open as another option for New Mexico residents, even after the enactment of the ACA. It is funded through premiums and assessments on carriers with health insurance business.
- The Pool's Board of Directors intends it to be a safety net, which allows individuals to obtain coverage outside of the open enrollment period. Other members have voluntarily opted out of the Marketplace plans because they are familiar with the coverage offered by the pool.

Missouri Primary Care Association, Joe Pierle

- The Missouri Primary Care Association is the Association representing Federally Qualified Health Centers in the Missouri. Federally Qualified Health Centers are required by federal law to serve a medically underserved population or a medically underserved area, but they must be open to all regardless of an individuals' insurance status.
- There are 29 FQHCs in Missouri, operating 200 locations and they serve as a one-stop-shop for medical, dental, and behavioral health care.
- FQHCs operate on a sliding fee scale, based on income and family size. Anyone with an income over 200 percent of the Federal Poverty Level is charged a full office rate.
- 94 percent of the patients served by FQHCs have incomes under 200 percent of the Federal Poverty Level.
- 20 percent of patients served do have private insurance, and this number has increased significantly in recent years.
- Mr. Pierle commented that the biggest challenge the FQHCs see with Exchange Plans are the high deductibles. Patients are insured, but the deductibles are so high that they don't actually use their benefits and instead seek care at the FQHC and take advantage of the sliding scale.
- The FQHCs in Missouri have been very involved in the Medicaid Primary Care Health Home Initiative and other chronic disease management programs championed by MO HealthNet.
- Mr. Pierle also commented that it is very important to address social factors impacting health, such as transportation difficulties.

